MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND 10138 CERTIFICATE OF DEATH

10104

1. PLACE OF DEATH o. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceded on STATE Mary land	I COLLEGE	desidence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town) Rural Westmanster	c. LENGTH OF STAY IN 16 4 Months	c. CITY OR TOWN (If outside con Rural, Westminst	4 -	t Valley)
d. NAME OF HOSPITAL (If not in hospitol, give street of National N	address)	d. STREET ADDRESS Westminster, Md	. R. D. 7	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) Namie	Irene Middle B	auerline 4. DAT		Day Year 19
5. SEX 6. COLOR OR RACE 7. MARR Female White WIDOWE		B. DATE OF BIRTH 7/15/1891		UNDER 1 YEAR IF UNDER 24 HRS. Onths Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Housework	kind of Business or induster own home	Carroll Co., M		U.S.A.
13. FATHER'S NAME William Thomas Turfle		14. Mother's Malden NAME Malvinia Simps	on	
(Yes, no, or unknown) (If yes, give war or dates of service)		FORMANT S. Mose Kecfer, W	Address estminster,	Md. R. D. 2
18. CAUSE OF DEATH [Enter only one cause per line part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave rise to immediate cause (o), stoting the under-lying cause last. C PART II. OTHER SIGNIFICANT CONDITIONS C	Aute Coro Menoseler	othe Heart D		INTERVAL BETWEEN ONSET AND DEATH 30 min
Thypertennian	moderal			PERFORMED? YES NO
	Not while foo	ACE OF INJURY (Home, farm, 20f. (Catory, street, office bldg., etc.)	City or town)	(County) (Stote)
21. I certify that (I) (this haspital) attends as the deceased alive an Synt 1. 220. SIGNATURE SULVEL N) July 22c. PHYSICIAN'S NAME (Type) HAROLD R. HAND	7_1960, and that a	M.D. PHYS. MED. PHYS. DIRECTOR	m the causes and c	22b. DATE SIGNED 9-17-6
230. BURIAL, CREMATION, 23b. DATE THEREOF BUTIAL Specify 9/19/60 24. FUNERAL DIRECTOR'S SIGNATURE CHARGE A CHITCHE	Westminster C ADDRESS Littlestown, I	Cemetery West 250. REC'D BY REC	ISTRAR 256 REGISTRA	rroll Co., Md. R'S SIGNATURE A Thank

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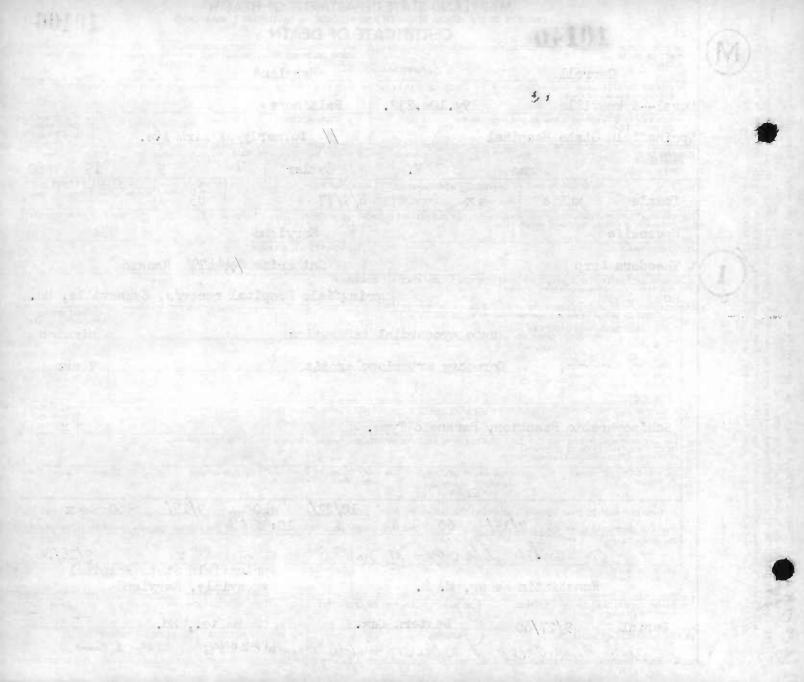
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PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND Carroll Maryland b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Rural--Sykesville 19y.10m.23d. Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION Springfield State Hospital formerly of Kirk Ave. YES NO NAME OF Middle 4. DATE First Month Yeor OF DEATH V. Butler (Type or print) Emma 9 19 60 S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthdoy) Months female white DIVORCED | WIDOWED K 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) USA Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Theodore Lerp Catherine WenkeWV Henkle 17 INFORMANT Address IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. Springfield Hospital records, Sykesville, Md. no 1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY Acute myocardial infarction Minutes IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which Coronary arteriosclerosis Years gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? Schizophrenic Reaction, Paranoid Type. YES NO 20g. ACCIDENT WAS UNDERLYING A
OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, form, Doy, Year 20d. INJURY OCCURRED 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc.) While Not while ot work p. m. 21. I certify that (this haspital) attended the deceased fram 10/22/ 1960, that 05 (we) last and that death accurred at 0: M, from the causes and an the date stated above. 1900 saw the deceased alive on 9/16/60 IGNED ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22c. PHYSICIAN'S 22d. ADDRESS Springfield State Hospital NAME (Type) Konstantin Weber, M. D. Sykesville, Maryland 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (Stote) REMOVAL (Specify) Western Cem Balto. Burial 24. FUNERAL DIRECTOR'S SIGNATUR **ADDRESS** 25a. REC'D BY REGISTRAR 55h REGISTRAR'S SIGNATURE SEP 2 8 '60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10107

)	101/1 CERTIFICA	TE OF DEATH
	1. PLACE OF DEATH o. COUNTY AVVOII MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Residence before admission)
	b. CITY OR TOWN (If outside corporate limits, write RURAT and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
15	d. NAME OF HOSPITAL (If not in hospital, give street address) OR-INSTITUTION Springfield Starte Hospital	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES \(\) NO \(\)
	3. NAME OF DECEASED (Type or print) AND PRINT OF PRINT O	CARR DATE Sept, Day Year DEATH Sept, 57, 1960
1	S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 7 Nov. 1900 5
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM	MARYLAND U,S'
	CHARLES R. CARR	HATTIE BOSLEY
	15. WAS DECEASED EVER IN U. S. ARMED FÖRCES? 16. SOCIAL SECURITY NO. 17. I (If yes, give war ar dates of service)	pringfield State Hosp Records
	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Punture death	Cominal Horta ANEUYSM INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if ony, which gove rise to immediate (b) Artariose	levotic Heart Disease yvs.
	couse (o), stoting the under. DUE TO CHREVA / 131	Arterioselarosis Yrs.
0	Seat II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO BEATH BU SCALING THE PUBLICATION OF THE PUBLICATION O	MONARY TUE, OOZX PERFORMED? YES NO
	OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ED. (Enter noture of injury in Port I or Port II of item 18.)
	ZOc. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED to Mour o. m. 19 While Not while of work of work of the control of t	LACE OF INJURY (Home, form, 20f. (City or town) (County) (State) street, office bldg., etc.)
	21. I certify that (I) (this haspital) attended the deceased from saw the deceased alive an 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	death accurred a 2. M. fram the causes and an the date stated abave.
,	Constin Cel Compo	M.D. PHYS. MED. STAFF 9 27 6 SIGNED
1	22c. PHYSICIAN'S NAME (Type)	Springfield State Hosp, Sylvesnille Wed
9	23a, BURIAL, CREMANION, 23b. DATE THEREOF 60 23C NAME OF CEMETERY OF THE CONTROL OF CEMETER OF THE CONTROL OF THE CONTROL OF CEMETER OF THE CONTROL OF T	Sead a WWW HAM O'Stoles III
3,	EUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS	DATE 230 REGISTRAR 256. REGISTRAR'S SIGNATURE Chilms S. Kraus

TO HOSPITAL STTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haur may be rekt by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in page 3 shauld be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and the State Board at Health priar to burial, cremation, ar remayal, and in any event, within 72 pours after death. VR A15 (4) 1SM 9/59

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4

e funeral directar,

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		10149		CERTIFICA	ATE (OF DEATH	1			11	1100
	Carroll			MARYLAND	2. U	SUAL RESIDENCE (W. STATE Maryland	/here decease	d lived. If institution b. COUNTY	ederi	e before ck	odmission)
	b. CITY OR TOWN (If RURAL and give ne Henryton	outside corporate limit arest tawn)	s, write	c. LENGTH OF STAY IN 16		CITY OR TOWN (IF Frederick					st town)
	OR INSTITUTION	AL (If not in hospital, g State Hos)		_		street Address 412 Middl	Le All	еу			IS RESIDENCE ON A FARM? (ES INO []
1	NAME OF DECEASED (Type or print)	Mon:		Middle		Carter	4. DATE OF DEATH	Sept		Day 9	Yeor 19 60
5. 9	Male	Negro	WIDOW		1	2-17-05		9. AGE (In yeors lost birthdoy) 54 yrs.	-		UNDER 24 HRS dours Min.
10a	. USUAL OCCUPATIO during most of work Laborer	ing life, even if refired)	lane 10b.	None	JSTRY 1	New Orle		The state of the s		S.	A.
13.	Charlie C	arter			14.	MOTHER'S MAIDEN Cora Bel		54.12		Y	La di
		R IN U. S. ARMED FOR If yes, give war or dates of se	rvice)	SOCIAL SECURITY NO. 17. 29-07-3480	Mo	ant nroe Cart	ter -	Add Patient	ress		
FICATION	Conditions, if or gove rise to in couse (o), stoting t lying couse lost. Part II. OTH	the <u>under-</u> DUE TO	CI	remia and Mod hronic jlomer CONTRIBUTING TO DEATH BU	ulo	nephritis			'EN IN PART		WAS AUTOPSY PERFORMED? ES NO
CERT	20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OCCURR	ED. (Ent	er noture af injury in	Port I ar Po	rt II of item 18.)			
MEDICAL	20c. TIME OF INJURY Hour o. m. p. m.	Y Manth, Day, Yeo	While of wor	Not while fi		F INJURY (Hame, far treet, office bldg., et		y or tawn)	(Co	ounty)	(Stote
	saw the decease 22a. SIGNATURE And 22c. PHYSICIAN'S NAME (Type)	ed alive an Se	ne.	ded the deceased from. 9. 19 60, and that Lacy ulans. Supt.	M.D.	accurred at 3	MED.	staff PHYS.	d an the	date s	tated abave 22b.DATE SIGNED
L		9-14-196	F O	23c. NAME OF CEMETERY Mount Aub	OR CREA	MATORY	23d. LOCA	altimore,	or county)	land	(Stote)
	7.W.	Saun	de	24 All Sa	aint.	S St. DATE S	EP 1 6 '6			Kine	

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ATTENDING PHYSICIAN: The law requires that the death certificate be

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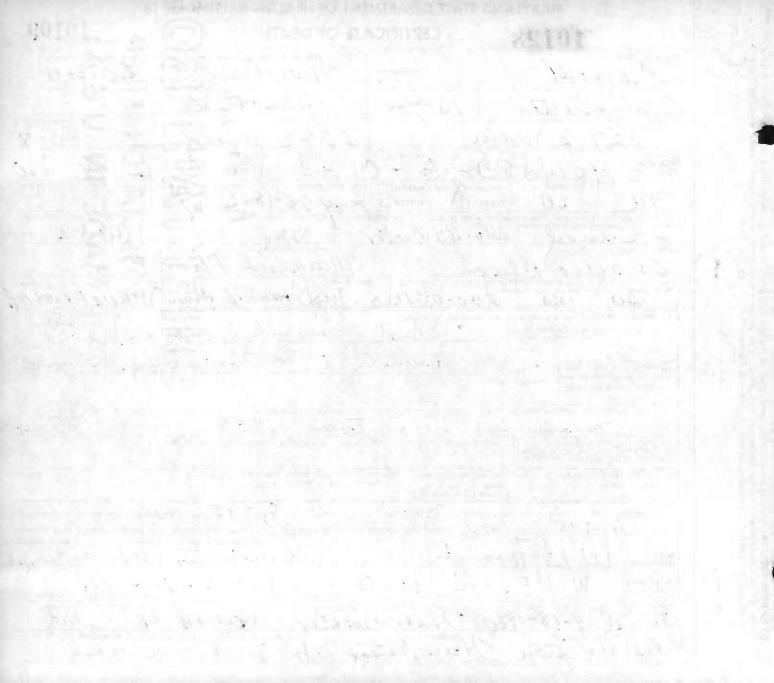
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



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PLACE OF DEATH

a. COUNTY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 8 FilmG272 CERTIFICATE OF DEATH Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY MARYLAND Carroll Marvland Carroll c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster vrs. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 99% Liberty Street 99% Liberty Street YES NO X 4. DATE First Middle Last Yeor Month Day William DEATH 24 Close 19 60 Sept. IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years last birthdoy) Months Days Hours Min. DIVORCED | white WIDOWED | 12. CITIZEN OF WHAT COUNTRY? Carroll Co... U.S.A Maryland 14. MOTHER'S MAIDEN NAME Annie Fisher INFORMANT 991/2 Liberty St. 215-20-8612 Mervin Westminster. Md. Close INTERVAL BETWEEN ONSET AND DEATH DUE TO

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION NAME OF DECEASED (Type or print) George 5. SEX 6. COLOR OR RACE male 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) during most of working life, even if retired) U. S. Army, retired 13. FATHER'S NAME Joseph C. Close 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. World War ves 18. CAUSE OF DEATH [Enter only one couse per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o Conditions, if ony, which gave rise to immediate DUE TO couse (o), stoting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Part I or Port II af item 18.) 20c. TIME OF INJURY 20d. INJURY OCCURRED Doy, Year 20e. PLACE OF INJURY (Hame, farm, 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc. Hour o. m. While Not while at wark at work p. m. 1900, that I last saw the deceased I attended the deceased from and that death occurred at $4.30 P_{\rm M}$, from the causes and an the date stated above. alive an DDRESS (Street, city or to ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22d. LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY (Stote) REMOVAL (Specify) National Burial Cemeterv Baltimore Maryland 24g. REC'D BY REGISTRAR 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24b. REGISTRAR'S SIGNATURE

DATE SEP 2 8 '60

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MARYLAND STATE DEPARTMENT OF HEALTH 101 - DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY	Carroll	MARYL	- 13	a. STATE Ma	rylan	deceased liv	ed. If instituti b. COUNTY	on: Residen	rro]	odmissi 1	on)
b. CITY OR TOWN	(If autside corporate limits, write negrest town)	c. LENGTH OF STAY I	IN 16	c. CITY OR TO	Wood Wood	de corporote	limits, write R	URAL ond	give near	est town)
d. NAME OF HOSP OR INSTITUTION	tTAL (If not in haspital, give stre	et address)		d. STREET ADI	DRESS						FARM?
3. NAME OF DECEASED (Type or print)	ENJAMIN First	F. Middle	CONDO	N Lost		DATE OF DEATH S	eptemb		10,		rear 19 60
5. SEX Male	White wido	RRIED NEVER MARRIED	J	anuary	12,18	390	AGE (In years lost birthdoy) 70 yrs.	IF UNDER Manths	Days Days	Haurs	R 24 HR Min.
10a. USUAL OCCUPAT during most of wo Painter 13. FATHER'S NAME	ION (Give kind of work done 10 rking life, even if retired)	b. KIND OF BUSINESS OF		Mary Mary	land		η)		U. S		OUNTRY
	rville Cond	on		Susar		Pick	ett				
15. WAS DECEASED EV	ER IN U. S. ARMED FORCES?		17. INFO		MILOUI	TION	Add	ress			
Yes, no, or unknown)	(If yes, give wor or dates of service)	219-12-173	8 A	ugustu	s Con	ndon.	Wood	bine	. Ma	rvl	and
Canditians, if gave rise to cause (o), stating lying cause last	immediate g the <u>under-</u> : (b) DUE TO	eart dear	esu,	des	heles	m	elleti	y	19	95 to	0
САТІС	THER SIGNIFICANT CONDITION /AS_UNDERLYING [] 20b. D	ESCRIBE HOW INJURY OF						EN IIN FAR		PERFO	RMED?
OR CONTRIBUTION (IF EITHER, NOTIF 20c. TIME OF INJUINATION OF INJ	- 10 Whi		20e. PLACE factor	OF INJURY (Ho y, street, affice b	ome, form, 2 bldg., etc.)	20f. (City ar	tawn)	((County)		(Stot
21. I certify the saw the decer 220. SIGNATURE	at (1) (this haspital) atte	anded the deceased of the second of the seco		ATTENDING	-		causes ar	19	e date	stated	
22c. PHYSICIAN'S NAME (Type)		all M. D,		22d. ADDRES	s kesvi		Maryl		10	Seyn	16
Burial, CREMATI	Sept.13.19	23c. NAME OF CEME	svil	_	230	Cari	N (City, tawn,		Mary	State	9
24. FUNERAL DIRECTO	R'S SIGNATURE Waltz, Winfi	ADDRESS	land		25a. REC'D BY			STRAR'S SI			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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		CERTIFICA	TE OF DEATH				7 (1
1. PLACE OF DEATH G. COUNTY Car	roll	MARYLAND	2. USUAL RESIDENCE (V		b. COUNTY	on: Residence b	efore admis	ision)
b. CITY OR TOWN (IF RURAL and give nea Rural - Syke	outside corporate limits, write rest tawn)	57y.8m.19d.	c. CITY OR TOWN (III Baltimor		rate limits, write RI	URAL and give	nearest tow	n) 4
OR INSTITUTION	L (If not in hospital, give street State Hospita		d. STREET ADDRESS	? 71.	nknor	wn	ON	SIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	First Salvatora	Middle	Decormelo	4. DATE OF DEATH	Mon 9		Doy 30	Year 19 60
s. sex female	6. COLOR OR RACE 7. MARR white widows		B. DATE OF BIRTH 1866?		9. AGE (In years last birthdoy) 94? yrs.	Manths Day		
10a. USUAL OCCUPATION during most of working Laundress	(Give kind of work done 10b. ng life, even if retired)	KIND OF BUSINESS OR INDU	ISTRY 11. BIRTHPLACE (SIO		ountry)	12. CITIZEN	OF WHAT	COUNTRY
13. FATHER'S NAME	eknown		14. MOTHER'S MAIDEN	Thuk.	noun)			
	IN U. S. ARMED FORCES? yes, give war or dates of service)		NFORMANT Spring	-		ykesvil	le, M	Id.
PART I. DEATI	2	ne for (o), (b), and (c).]	tive myocard	itis	AS SE		vea	D DEATH
Canditions, if on gove rise to im couse (o), stoting th	mediate (teriosclerotic	cardio-vasc	ular di	sease		yea	rs
PART II. OTHE	R SIGNIFICANT CONDITIONS CONTROL Reaction			MINAL DISEASE	E CONDITION GIV	'EN IN PART 1(c	PERFO	AUTOPSY ORMED?
20g. ACCIDENT WAS OR CONTRIBUTING [(IF EITHER, NOTIFY N	CAUSE OF DEATH	CRIBE HOW INJURY OCCURR	ED. (Enter nature of injury i	n Port I or Part	t II of item 18.)			
Y 20c. TIME OF INJURY Hour o. m. p. m.	While	NJURY OCCURRED 20e. P Not while k at work	LACE OF INJURY (Hame, fa actory, street, office bldg., e	rm, 20f. (City	or town)	(Cour	ity)	(State
21. I certify that saw the decease	30 (this haspital) attended alive an 9/30/		12/31 1 death accurred at2:	902 AMP 500, Fram	9/30 the causes an	, 19_60,	that (10)	(we) las d abave
22a. SIGNATURE	istoutile 1	Veber	M.D. ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	3,163	9/30	2b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)	Konstantin Web	er, M. D.		_	ield Stat Lle, Mary	_	tal	
23a. BURIAL, CREMATION REMOVAL (Specify)	1, 23b. DATE THEREOF	23c. NAME OF CEMETERY	OR GREMATORY	23d. LOCAT	MON (City, town,	Canty)	(Sto	med med
24. FUNERAL DIRECTOR'S	SIGNATURE SHAPE	Sukesville.	DATE DATE	CT 4 '6	n _	STRAR'S SIGNA	TURE /	

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	D FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director,	page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2'shauld be filled with	1
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10132

10114

CERTIFICATE OF DEATH

	Reg. Dist. No.
1. PLACE OF DEATH O. COUNTY CANALL MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and, give nearest town) d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION	c. CITY OR TOWN (Ilf outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
3. NAME OF DECEASED (Type or print) S. SEX 6. COLOR OR RACE WIDOWED DIVORCED DIVORCED	8. DATE OF BIRTH 9. AGE (In years lost birthday) No A FARMY YES NO A FARMY
100. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) 13. FATHER'S, NAME	
15. WAS DECEASED EVER IN D. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 218-24-12-7 [18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]	INFORMANT Address Sum attress Mis D. Hospital Mothers Interval Between
PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (of DUE TO Conditions, if ony, which gove rise to immediate couse (o), stating the under- lying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU	IT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?
200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ED. (Enter noture of injury in Port I or Port II of item 18.)
	PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State bactory, street, office bldg., etc.)
ACTUAL SIGNATURE COCCESSIONATURE	h occurred of 15 P.M. Hom the couses and on the date stated above ADDRESS (Street, city or town, state) M.D. DATE SIGNED ADDRESS (Street, city or town, state)
PHYSICIAN'S DA ERESE WAR PROBLEM TO THE PROBLEM TO	2 ametery Rural westpumter ma
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	240. RECID BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

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e. IS RESIDENCE ON A FARM?

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INTERVAL BETWEEN

ONSET-AND DEATH

PERFORMED? YES NO

(State)

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YES NO

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24. FUNERAL DIRECTOR'S SIGNATURE

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1. MARYLAND

25b. REGISTRAR'S SIGNATURE

2Sq. REC'D BY REGISTRAR

CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence befare admission) PLACE OF DEATH a. COUNTY a. STATE b. COUNTY County Carroll MARYLAND Baltimore City b. CITY OR TOWN (If autside carporate limits, write 47 years c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) RURAL and give nearest tawn) Sykesville 3 mos. 25 days Baltimore d. NAME OF HOSPITAL (If not in haspital, give street address)
OR INSTITUTION d. STREET ADDRESS e. IS RESIDENCE ON A FARM? B. Federal Street. YES NO X Springfield State Hospital NAME OF Middle 4. DATE DECEASED McCall Flynn September 26 1060 Rosa Agnes DEATH (Type ar print) 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED S. SEX B. DATE OF BIRTH last birthday) Manths Days Haurs Female White DIVORCED [WIDOWED 1 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during mast af warking life, even if retired) At Home U.S.A. Maryland Housewife 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Hugh McCal Sarah Kelly 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address Springfield Hospital Records, Sykesville, Md. No 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) DUF TO Arterial Schlerotic Heart Disease Conditions, if any, which Tears gave rise to immediate DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Schizophrenic reaction, paranoid type. YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Hame, farm, 20f. (City ar tawn) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) While Nat while at wark to September 60 that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased from May 3 19 60, and that death accurred at saw the deceased alive on from the causes and an the date stated above 22a. SIGNATURE SIGNED ATTENDING 9-26-60 M.D. DIRECTOR -22c. PHYSICIAN'S 22d. ADDRESS NAME/(Type) Agustin del Campo, M.D. Springfield State Hospital, Sykesville, Md. 23g. BURIAL CREMATION, 23b. DATE THEREOF 23d. LOCATION (City, tawn, ar caunty) REMOVAL (Specify) 9/29/60 Baltimore, Md. Baltimore National Burjal

ADDRESS

4611 Park Heights, Balto, Md. DAKEED 2 8'60

funeral director pe O .5 and physici ottending please by mit. gned burial-transit p g physician. detach RECTOR: af FUNERAL page 3 0

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

TO FUNERAL EXECTOR: After this certificate has been signed by the attending physician and campletely filled in page 3 shauld be detached far use as the burial-transit permit. Then please remayer carbon papers. Pages 1 and the registrar prior to burial, crematian, ar remayal, and in any event within 7/2 hours after death. TO HOSPITAL

VS A15 (4) 15M 9/55

10133	CERTIFICA	ATE OF DEATH	Clester III	Reg. Dist. No.	10120
1. PLACE OF DEATH O. COUNTY ARROLL	MARYLAND	2. USUAL RESIDENCE (Who o. STATE	re deceased lived. If institution b. COUN	ITY - A - S	odmission) 6 L L
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER -	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF ON	itside corporote limits, write	e RURAL and give near	est fown)
d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION	address)	d. STREET ADDRESS	VSTLVANI	A AVE.	ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) LEVI First EL	MER GI	4MBER	4. DATE OF DEATH SE	Aonth Day	Year 1960
M WIDOW		B. DATE OF BIRTH 9/23/18		Months Days	Hours Min.
OAMBEN	BARBER -	MARYL	AND	12. CITIZEN OF	WHAT COUNTRY?
13. FATHER'S NAME WILLIAM GAM	BER	14. MOTHER'S MAIDEN N.	??		17/53
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. or unknown) (If yes, give wor or dates of service)	SOCIAL SECURITY NO. 17.	WARD BAIL	EY-WESTA	MINSTER	MP.
PART 1. DEATH WAS CAUSED BY: MMEDIATE CAUSE (o)	CONTRIBUTING TO DEATH BUT	na			WAS AUTOPSY PERFORMED? YES NO
20c. TIME OF INJURY Month, Day, Year 20d. I While	NJURY OCCURRED 20e. PI Not while rk at work	ACE OF INJURY (Home, form, ctory, street, office bldg., etc.)	20f. (City or town)	(County)	(Stote)
alive an Section 13. 19/ ACTUAL SIGNATURE PHYSICIAN'S E PEFS F	Reus Wilkens		M, from the causes	and an the date	
220. BURIAL, CREMATION, 22b. DATE THEREOF	PROVIDEN	CE	CAMBE	n, or county)	(Stote)
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS Mes Inc	DATE DATE		GISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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Certifica	g physic	remove	vithin 72 hours ofter death.
death	Hendin	pleose	vithin 7

	10150		CERTI	FICA	TE OF D	EATH			Reg. Dist. N		012
o. COUNTY			MARY	rland	2. USUAL RESID	RY L	AND	lived. If instituti b. COUNTY		etore admis	ssion)
b. CITY OR TOWN	(If outside corporate lime nearest town)	nits, write	c. LENGTH OF STAY	IN 1b	c. CITY OR T	OWN (If or	utside corpora	te limits, write R	URAL ond give t	nearest tow	m)
NEW	WINDSOR		YEARS		NE	8/ 1	VIND.	SOR	RU	MHL	
d. NAME OF HOS	PEDFORD	give street	oddress)		d. STREET A	EDFO.	RD			ON	SIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	CHARLES	GE GE	ORGE	GRI	lost PHA-M		4. DATE OF DEATH	SEP7	oth	Doy 4	Year 19 60
S. SEX	6. COLOR OR RACE	7. MARI WIDOW	RIED ATÉVER MARRI		B. DATE OF BIRTH	180	99 9	AGE (In years last birthdoy)	Months Day	-	
Oo. USUAL OCCUPA	TION (Give kind of work torking life, even if retires	done 10b.	KIND OF BUSINESS C	OR INDUS	TRY 11. BIRTHPO	ACE (Stote	or foreign cou	intry)	12. CITIZEN	OF WHA	T COUNTR
WARE HOL 3. FATHER'S NAME	ISE - SHOE		MFG		14. MOTHER'S	KYLI	TIVU		4	1.17	_
HARR	Y G-RAH	AN)		SOP1	41A		ESS			
5. WAS DECEASED (Yes, no. or unknown)	VER IN U. S. ARMED FO		SOCIAL SECURITY NO). 17, H	FORMANT	0 000	10.10	Add	ress	- 13	
NO	110	.2/	13-05-1254	4 1.1	ENE (28/11	AM	NEW	WIND:	SOR	11.
	DEATH [Enter only one c	ouse per li	ne for (o), (b), and (c).]					110	NTERVAL B	ETWEEN D DEATH
PART I. I	DEATH WAS CAUSED BY:	0) (10	2 1 Pros	lal	2 with	mil	arton	is		18 m	
117	DUE TO	o '	0								
Conditions, i		b)									
gove rise to couse (o), stati		0									
lying couse lo		(c)									
PART II.	OTHER SIGNIFICANT COL	NDITIONS	CONTRIBUTING TO DE	ATH BUT	NOT RELATED TO	THE TERMIN	NAL DISEASE	CONDITION GIV	EN IN PART 1(a)	PERF	AUTOPSY ORMED?
200. ACCIDENT	WAS UNDERLYING AND CAUSE OF DEATH	20b. DES	CRIBE HOW INJURY C	CCURRE), (Enter nature of	injury in P	art I or Port I	l of item 18.)			
20c. TIME OF IN.	n. 10	20d. I While at wor	NJURY OCCURRED Not while		CE OF INJURY (It tory, street, office			er tawn)	(Count	'γ)	(Stote)
21. I certify	that I attended the	deceas	ed fram. De	k.z.	, 1988	, 10 9	- 20	+ , 1960	that I last	saw the	decease
alive on	-23	, 19_	Con and that	death	accurred at	2 45	LM, fram				
ACTUAL SIGNATURE	annes I.	Th	arsh		W.D		ADDRESS (Stre	et, city or town,	stote)	9-	26-
PHYSICIAN'S NAME (Type)	TAMEST	- M	ARSH		1	restu	ruel	4	mid		
220. BURIAL, CREMA REMOVAL (Spec	TION, 226. DATE THERE	OF GO	PIPE	CR	EEK EEK		CARI	POLLL	CC	(Sta	ne)
FUNERAL DIRECT	OR'S SIGNATURE	71	ADDRESS	1		240. REC'D		AR 24b. REGI	STRAR'S SIGNAT	URE	
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RESEARCH AND RECORDS - BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH directar 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission Carroll o. COUNTY b. COUNTY MARYLAND Maryland CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) h yrs.I mot. Sykesville, Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION Springfield State Hospital YES NO 709 Belgian Avenue Baltimore 18 Middle Year filled DECEASED (May) Ellen Hall DEATH (Type or print) 19 60 B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthday) Months Doys Female White WIDOWED T DIVORCED | 69 yrs 12. CITIZEN OF WHAT COUNTRY? 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) during mast of working life, even if retired) (Baltimore) U.S.A. Housekeeper and 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Frank Osborn Margaret Hodges 17 INFORMANT IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Springfield State Hospital, Sykesville, Md. INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY Broncho-Pneumonia Days IMMEDIATE CAUSE (o) DUE TO Arterio-sclerotic Cardio-Vascular Disease Canditians, if any, which Months gned gave rise to immediate DUE TO couse (a), stoting the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? Involutional Psychotic Reaction burial YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) factory, street, affice bldg., etc.) Hour o. m Not while While of work at work p. m. 1960, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased fram. , and that death accurred a saw the deceased alive an TM, fram the causes and an the date stated above. DIRECTOR: 22b. DATE 22o. SIGNATURE ATTENDING MED. M.D. 22c. PHYSICIAN'S 22d. ADDRESS Springfield State Hospital Agustin Campo FUNERA 230. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State) poge the Sto 9-6-60 Mt. Olivet Cemetery Baltimore 0 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR'S SIGNATURE 2Sq. REC'D BY REGISTRAR

DATE SEP 8

Wm. Cook, Inc., 1217 St. Paul Street

(Stote)

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15M 9/5B

Rea. Dist. No.

Day

IF UNDER 1 YEAR IF UNDER 24 HRS

Hours

INTERVAL BETWEEN ONSET AND DEATH

PERFORMED?

YES NO

(State)

(State)

12. CITIZEN OF WHAT COUNTRY?

Doys

USA

(County)

that I last saw the deceased

e. IS RESIDENCE

ON A FARM?

YES NO NO

Year

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Carroll

Months

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4	Exp may be retormed by the haspital ar attending physician.	d be detached far use as the burial-transit permit. Then please remove carban papers. Pages 1 and schauld be filed with	the State Board of Health prior to burial, crematian, or removal, and in any event, within 74 hours after death.	
TO HOSPITAL ATTENDING	way be reformed by the hasp	page 3 should be detached f	the State Board of Health pri	4
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prificate has been signed by the ottending physician and campletely filled in the funeral director,	as the burial-transit permit. Then please remove carban papers. Pages 1 and what be filed with	
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camplete	papers.	orial, crematian, or removal, and in any event, winter 72 hours after death.
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ate has	e buria	cremat
rtific	as th	irial,

1.	PLACE OF DEATH			2. USUAL RESI	DENCE (Where	deceased liv	ed. If institution	on: Residence be	efore admission)
		Carroll	MARYLAND	U. STATE	Marvl	end	B. COUNTY		
	b. CITY OR TOWN (I RURAL and give no	f outside corporate limits, write	c. LENGTH OF STAY IN 16	c. CITY OR	OWN (Il outsi	ide corporote	limits, write RI	URAL ond give r	nearest town)
	Sykesvi		18 years	Balt	imore		~	VOI	-4
	d. NAME OF HOSPIT	AL (If not in hospital, give street	oddress)	d. STREET A	DDRESS			31 38	e. IS RESIDENCE ON A FARM?
		ngfield Stat	e Hospital	318	Norri	s Sti	reet		YES NO
3.	NAME OF DECEASED	First	Middle	Los	1 4	OF DEATH	Mont	th	Day Yeor
	(Type or print)	atherine	Ha	rtman		DEATH	9		1960
S. :	SEX	6. COLOR OR RACE 7. MAR	RIED NEVER MARRIED	8. DATE OF BIRT	1	9.	AGE (In years lost birthdoy)	Months Doy	AR IF UNDER 24 HRS.
	Female	White WIDOW	DIVORCED	2-8-91	40		69 yrs.	Months Doy	Min.
10a	. USUAL OCCUPATION during most of work	ON (Give kind of work done 10b.	KIND OF BUSINESS OR INDU	ISTRY 11. BIRTHPL	ACE (Stote or	foreign count	try)	12. CITIZEN	OF WHAT COUNTRY?
	TT	ner		Bal	to. M	d.		V.S.	A
13.	FATHER'S NAME	5 S S S S S S S S S S S S S S S S S S S		14. MOTHER'S	MAIDEN NAM	WE			
	Joseph E	Bander		Mary	Ward				
		R IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17.1	NFORMANT		100	Addr	ress	
110	s, no. or unknown)	Jir yes, give wor or dores or service)	Do	lores J	ohnso	n-626	Scott	Stree	et
	18. CAUSE OF DEA	ATH Enter only one couse per li						11	TERVAL BETWEEN
	PART I. DEA	TH WAS CAUSED BY: Adv	anced Pulmon	ary TBO	7			0	NSET AND DEATH
	000	DUE TO	<u> </u>						
П	Conditions, if o	A	SCVD						
	gove rise to in	mmediate (D)	0 1 2						
п	couse (o), stoting lying couse lost.	the under-	iabetes Mell	itua					
z		(c) 1			THE TERMINIA	U DISEASE C	ONDITION GIV	FN IN PART 1/o	19 WAS ALITOPSY
TIO	TAKI II. OIF	TER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BO	I NOI KELAILD IC	THETERMINA	AL DISEASE C	,	CIA HALAKI IO	PERFORMED?
FICA	20- ACCIDENT WA	C UNIDERLYING TO TOO DEC	CRIBE HOW INJURY OCCURR	FD /F-1 1	6 t-t t- 0	A Los Post II	of item 10)		YES NO
CERTIFICATION	20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	CAUSE OF DEATH MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURR	ED. (Enter noture o	r injury in For	T I OT POTI II	or tient to.)		
CAL	20c. TIME OF INJUR	Y Month, Doy, Year 20d. I	NJURY OCCURRED 20e. P	LACE OF INJURY	Home, form,	20f. (City or	town)	(Count	ty) (Stote)
MEDICAL	Hour o.m.	19 While of wor	TAOL MILLS	octory, street, office	e bldg., etc.)				
>	p. m.			8-31	1/1	2 to 9-	11	60	
		it (I) (this haspital) attend			100,00	_ ,			that (I) (we) last
		sed alive an 9-11-	180 and that	death accurre	d atvpM	, fram the	e causes an	d an the da	ite stated above.
	220. SIGNATURE	1,	00.6	M.D. PHYS.	G _ MED.		STAFF TO PHYS.		9-11-516NGD
1	22c. PHYSICIAN'S	prismi al	1 Campo	M.D. PHYS.		CTOR 🗌	PHYS		9-11-00
	NAME (Type)					770	4 7	T	2
	V.F	lgustin del U	ampo /	Spi	ingii	era s	tate 1	Hospit	91
230	BURIAL, CREMATIO	N, 23b. DATE THEREOF	23c. NAME OF CEMETERY				N (City, town,	or county)	(Stote)
I	REMOVAL (Specify)	9-13-60	Baltimore	e Cem.		Balto	. Md.		
24.	FUNERAL DIRECTOR	S SIGNATURE	ADDRESS	, ,	25a. REC'D E	REGISTRAL		STRAR'S SIGNA	
k	kn C Me	Music - 243	1-35 6 Oler	erst.	DATE	. 7 00	Ch	Thun S. Ka	and
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3.		11117.4 CERTIFICA	ATE OF DEATH Reg. D	ist. No.1 () 125
N	1.	ACE OF DEATH COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Reside	
		CITY OR TOWN (If autside corporate limits, write c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside corporate limits, write RURAL and	
		Rural - Sykesville 29yr.9mo.28da	rs Hagerstown	21032
15		NAME OF HOSPITAL (If nat in haspital, give street address) OR INSTITUTION	d. STREET ADDRESS	e. IS RESTDENCE ON A FARM?
10		Springfield State Hospital	410 McDowell Avenue	YES NO
		AME OF First Middle FCEASED ype or print) Mabel V.	Lost 4. DATE Month OF DEATH SEPTEMBER	Day Year 20 1960
	S. 5	114002	8. DATE OF BIRTH 9. AGE (In years IF UNDE	R 1 YEAR IF UNDER 24 HR
		Female White WIDOWED DIVORCED	9-16-1886 last bightday) Months	Days Haurs Min.
	10a	USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR INDU during most of working life, even if retired)	STRY 11. BIRTHPLACE (State ar fareign country) 12. CI	TIZEN OF WHAT COUNTRY
		Housewife	Ohio U	S.A.
	13.	ATHER'S NAME	14. MOTHER'S MAIDEN NAME	
1		William E. Butts	Annie Smith	
	15. (Ye	VAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 10. or unknown) (If yes, give war or dates of service)	NFORMANT Address	
1		No	Hospital Records	
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
		PART I. DEATH WAS CAUSED BY: Coronary Occlusi	on	Minutes
		420.1 DUE TO		
			Cardiovascular Disease	Years
		gave rise to immediate cause (a), stating the <u>under-lying cause last.</u>		
A	NO	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PA	RT 1(a) 19. WAS AUTOPSY PERFORMED?
0	CATION	Epilepsy.		YES NO
	CERTIFI	20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTION OF THE CONTRIBUT	D. (Enter nature of injury in Part I or Part II of item 18.)	
	MEDICAL	COc. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 40 Fa Haur a. m. P. m. 19 While at wark at wark	ACE OF INJURY (Hame, farm, 20f. (City ar tawn) ctary, street, affice bldg., etc.)	(Caunty) (State
		21. I certify that I attended the deceased fram2/7/60	19 ta 9-20 1960 that I I	ast saw the decease
		alive an September 20, 19 60 , and that death	accurred at 10:15 M, fram the causes and an th	
		0 0 1 00/1	ADDRESS (Street, city ar tawn, state)	DATE SIGNE
		SIGNATURE RAYSUMM HOCKLEY	M.D. Springfield State Hospital	9-21-60
1				
		PHYSICIAN'S NAME (Type) J. Raymond Gladue, M.D.	Sykesville, Maryland	
	220	BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY C	OR CREMATORY 22d. LOCATION (City, tawn, ar caunty)	(State)
		REMOVAL (Specify) Burial 9/23/1960 Rose Hill Cer	metery Hagerstown, Mary	land
		INTERNAL DIRECTOR'S CICALATURE	24g REC'D BY REGISTRAR 24b. REGISTRAR'S S	CALATURE
	23.	Suter Houser Funeral Home DDRESS Hagerstown		

20101 A CONTRACTOR OF THE CONTRACTOR north Ton Land Series The Lat Food (tronggo) on the as a 21 per Command Lines of the Control of the Commence of th overlat 0/23/1750 - hose Hill Company Description. Largers and nter - caren inamial Cons ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death. Page 4

TO HOSPITAL

VR A1S (4) 1SM 9/S9

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10126

	esidence before odmission) Somerset				
	b. CITY OR TOWN (If outside corporate limits, we RURAL and give nearest town) Henryton				
3	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital d. STREET ADDRESS 16 S. 44 Street				e. IS RESIDENCE ON A FARM? YES NO
	3. NAME OF First DECEASED (Type or print) Annie	Middle	Last 4. DATE OF DEATH	September 5	er 27 1960
		MARRIED MEVER MARRIED DOWED DIVORCED	B. DATE OF BIRTH 2-15-1887	1 1 1 1 1 1	NDER 1 YEAR IF UNDER 24 HRS. onths Days Hours Min.
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (State or foreign of Crisfield, Mo		2. CITIZEN OF WHAT COUNTRY? U. S. A.
	13. FATHER'S NAME Washington Mile	5	14. MOTHER'S MAIDEN NAME Annie Ward		
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		NFORMANT Annie Hearn-Patie	Address	
7	Conditions, if ony, which gove rise to immediate couse (a), stating the under. DUE TO	ONS CONTRIBUTING TO DEATH BU	insufficiency. P lateral pulmonary T NOT RELATED TO THE TERMINAL DISEASE D. (Enter noture of injury in Part I or Por	se condition given II	
	20c. TIME OF INJURY Manth, Doy, Year 2 Hour o. m. p. m. 19 2 21. I certify that (I) (this haspital) at	Od. INJURY OCCURRED While Not while twork of work tended the deceased fram.	LACE OF INJURY (Home, form, 20f. (Circle), street, office bldg., etc.)	y or lown) September	(County) (State)
/	saw the deceased alive an Sept 220. SIGNATURE Edgats M. Mg 22c. PHYSICIAN'S RAME (Type) Radgars M. 1	aculans	M.D. ATTENDING MED. DIRECTOR 22d. ADDRESS	STAFF PHYS.	n the date stated abave. 22b.DATE 9-27-6
3	23a. BURIAL, CREMATION, 23b. DATE THEREOF SEEMOVAL (Specify)	23c. NAME OF CEMETERY OF ABOUT 4 CO		TION (City, 19wn, or co	

1 . HIARD TO SHADOW TO SEATH

25b. REGISTRAR'S SIGNATURE

25a. REC'D BY REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

- 1	TATOR	CERTIFICA	TE OF DEATH	PER CONTROL CO	
1. PLACE OF DEATH o. COUNTY	Carroll	MARYLAND	2. USUAL RESIDENCE (W	nd. lf institution b. COUNTY	n: Residence before odmission) Carroll
b. CITY OR TOWN RURAL and give Harris	(If autside carporate limits, write nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If	outside carporate limits, write RU	RAL and give nearest town)
d. NAME OF HOSP OR INSTITUTION	Mt. Airt	oddress)	R. D.	Mt. Airy	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type ar print)	VIOLA First	Middle R.	HOOD	4. DATE Mont OF DEATH Septemb	/
s. sex Female	6. COLOR OR RACE 7. MARI	RIED NEVER MARRIED DIVORCED	B. DATE OF BIRTH February 24	9. AGE (In years last birthday) 65 yrs.	Manths Days Haurs Min.
during mast af wa	ION (Give kind of work done orking life, even if retired) Coat Factory	KIND OF BUSINESS OR INDU	Maryl 14. MOTHER'S MAIDEN	and	12. CITIZEN OF WHAT COUNTRY?
Y	Inkown			11A Owings	
1S. WAS DECEASED EV Yes. no. or unknown)	VER IN U. S. ARMED FORCES? 16.		NFORMANT BTL R. Hood	Mt. Airy, I	Maryland
Conditions, if gave rise to couse (o), statin lying cause last	g the under-	ash dinea	tus -	allering zu	1998 1860
PART II. O	THER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERM	NINAL DISEASE CONDITION GIVE	EN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO NO
	VAS UNDERLYING 20b. DES IG CAUSE OF DEATH FY MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURRI	ED. (Enter nature of injury in	Part I ar Port II af item 1B.)	
20c. TIME OF INJU Havr a. m p. m	. While	Nat while fo	LACE OF INJURY (Hame, for actary, street, office bldg., et		(Caunty) (State
	nat (1) (this haspital) attendased alive an Alexandra	Taglanger &	death accurred of the ATTENDING	AED. STAFF	d an the date stated above. 22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)		Mall, M. D.	22d. ADDRESS	ville, Mary	Land
23a. BURIAL, CREMAT	LA L	23c. NAME OF CEMETERY OF Prospect		23d. LOCATION (City, town, or Frederick Co	

ADDRESS

Maryland

ital ar attending physician.
this certificate has been signed by the attending physician and completely filled the burial-transit TO FUNERAL DIRECT
page 3 should be d
the State Board of P

ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after deoth. Page 4

TO HOSPITA

24. FUNERAL DIRECTOR'S SIGNATURE

C. M. Waltz, Winfield,

* CHIA . OF . C . A LES TILL BE THE . 11 party talk 8 Linear 200-29-0193 Cort H. Buck, No. 189, Marchand Howard S. H.11. M. S. Syxonville, Language Service Capt. 1. 1950 Prospect description of the Captain States and from Plantill Area Than See Law and the

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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	(IAI)
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1. PLACE OF DEATH o. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY MARYLAND Carroll Md. b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Winfield Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) IS RESIDENCE d. STREET ADDRESS ON A FARM? YES NO NO Golden Age Nursing Home 39.19 Edmondson Ave. NAME OF 4. DATE Middle Last Manth Day Year DECEASED MARTE RITZABETH HOPKINS (Type or print) DEATH 1960 6 IF UNDER I YEAR IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years lost birthday) Months Days Hours DIVORCED | WIDOWED ... Female Whi te 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State ar fareign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Md. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Albert J. Volkmann Emma L. Winter 17 INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Mr. Fred Volkmann - Svosset INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (6). ONET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (g DUE TO Conditions, if any, which gove rise to immediate DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO D 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Port II of item 18.) 20c. TIME OF INJURY Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a. m.

While Not while

of work

saw the deceased alive an

21. I certify that (I) (this haspital) attended the deceased from

of work

ATTENDING

22d ADDRES

and that death accurred at

M.D. PHYS.

DIRECTOR -

Co that (1) (we) last

M, from the causes and on the date stated above. 22b. DATE SIGNED

22a. SIGNATURE

REMOVAL (Specify)

22c. PHYSICIAN'S

23a. BURIAL, CREMATION, 23b. DATE THEREOF

9/8

23c. NAME OF CEMETERY OR CREMATORY

Balto-

23d. LOCATION (City, town, or county)

PHYS.

(State)

FUNERAL he Burial 10 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 1SM 9/59

to

DATE SEP 7

Balto. 256 REGISTRAR'S SIGNATURE 25g. REC'D BY REGISTRAR

arihur S. Kraus

SHIP IS STATE IN The state of the s s. denno de - manufactura de la companya de la comp . inc. . odina

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

10129

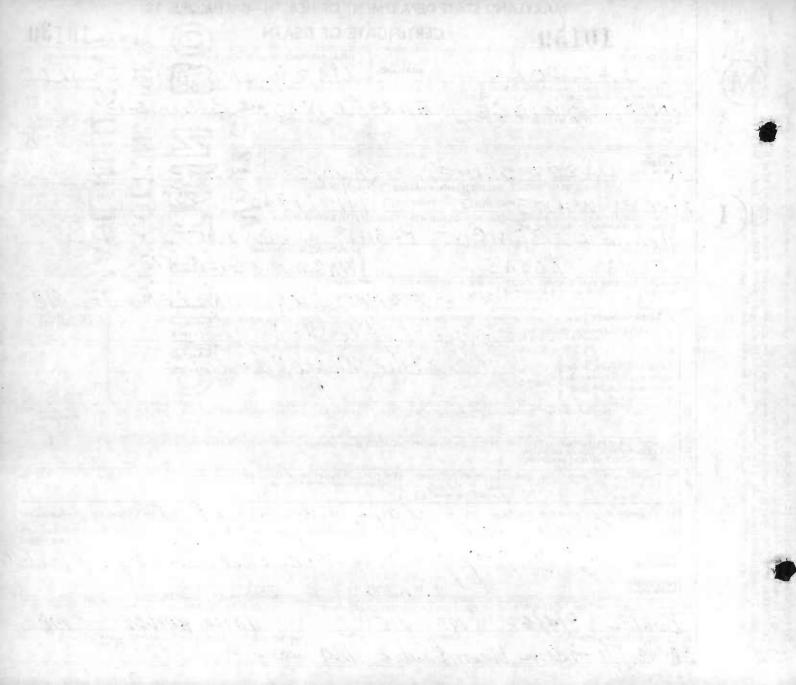
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1.	PLACE OF DEATH o. COUNTY Deflucted MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY b. COUNTY b. COUNTY
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUMERURAL and give nearest town) SUMERURAL RURAL RURAL OF STAY IN 16 C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
1	d NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION Juliflau aga bow Howl NOW ON A FARM? YES NOW NOW NOW NOW NOW NOW NOW NOW
	NAME OF DECEASED (Type or print) MARCELLA Widdle KNELLER 4. DATE OF DEATH SLEPT 24 1960
5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH No. 1/2 No.
100	o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 17. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY'S WHAT
13.	FATHER'S NAME 14 MOTHER'S MAIDEN NAME 14 MOTHER'S MAIDEN NAME 14 MOTHER'S MAIDEN NAME 14 MOTHER'S MAIDEN NAME
	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (If yes, give war, or dates of service) Will Ches Short Address Mallehester Mil
	18. CAUSE OF DEATH [Enter only one couse per line for (g), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) INTERVAL BETWEEN ONET AND DEATH ONET AND DEATH
1	443 X DUE TO Conditions if any which)
	gove rise to immediate couse (a), stating the under-lying couse lost. (b) DUE TO (c)
ATION	
CERTIFICATION	
MEDICAL	20c. TIME OF INJURY Month, Doy, Year Not while of work of two or w
	21. I certify that (I) (this haspited attended the deceased from 19 to 19 to 19 19 that (I) (we) las saw the deceased alive and that 2 19 19 to and that death accurred at 2 0 from the causes and an the date stated above
1	220 SIGNATURE M.D. PHYS. MED. STAFF SIGNED
	224 PHYSICIANS FLL WMASTIN 22d. ADDRESS.
23	Be BURIAL, CREMATION, 23b. DATE THEREOF 23c, NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town, or county), (Stole)
24	DERAL DIRECTOR STIGNATURE ADDRESS LEVEL MC 250. REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE DATE SEP 3 0'60 and S. Krous

FT A SO TO THE APPLICATION OF A PARTY. The thing there were the will be the series of the ofter death.

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that the death certificate be executed within 24

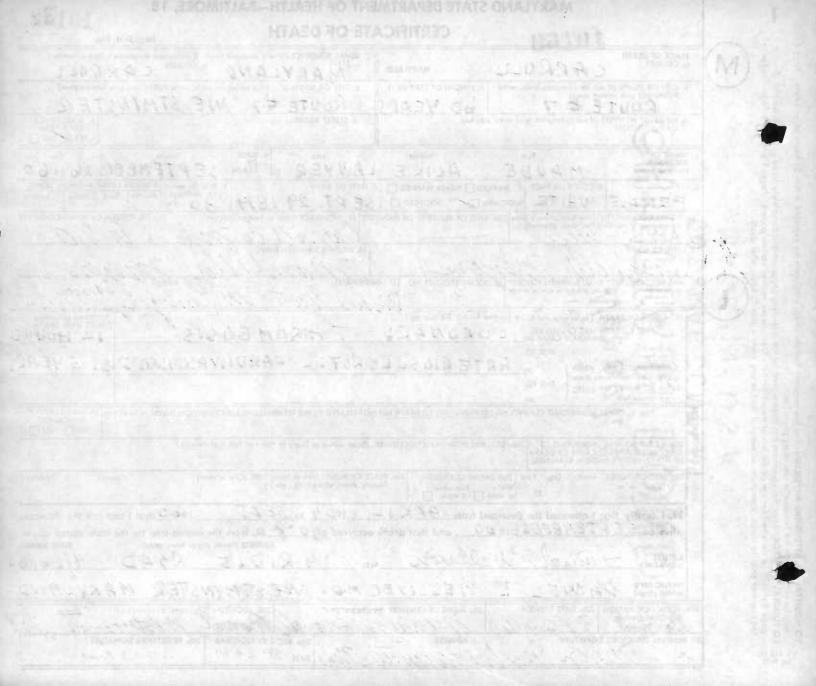
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



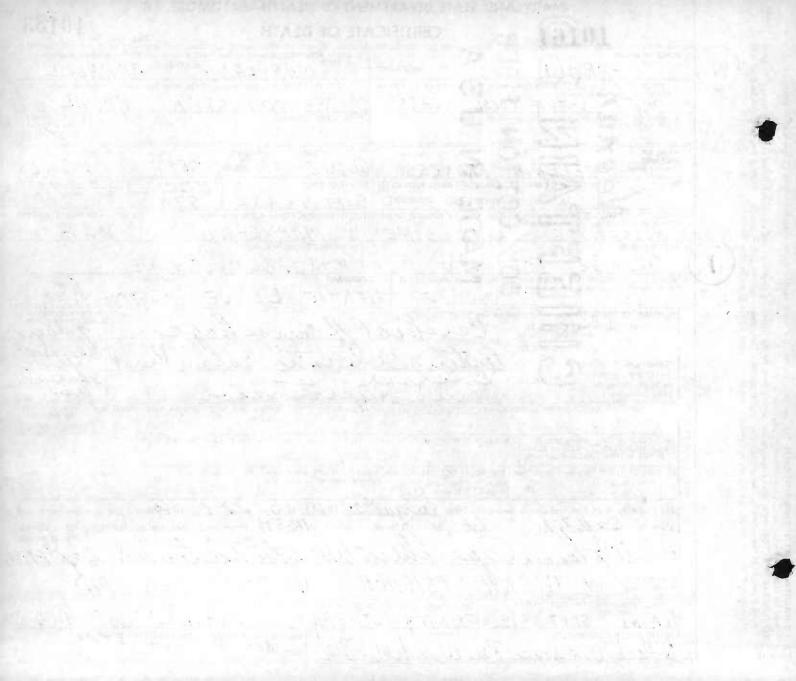
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MATYLAND STATE OFFATHER OF HEALT-LEADING TATE (MALYTEM A LAND THE PARTY AND THE PARTY Married Married Married Street, No. of Street, Street,

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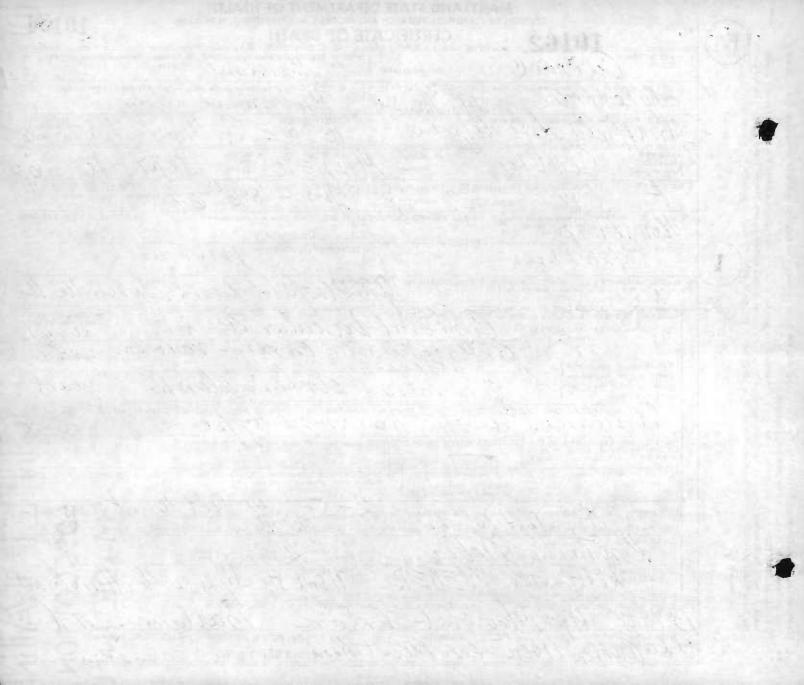
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs ofter death. Page 4

DIATINO HOSPITAL

	10169 Items CERTIFICA	TE OF DEATH	10101
	1. PLACE OF DEATH CAYYOLL MARYLAND	a. STATE Was b. COUNTY	te befare admission)
	b. CITY OR TOWN (If autside carporate limits, write RURAL land sive nedrest town)	c. CITY OR JOWN (If byside corporate limits, write-RURAL and g	jive nearest tawn)
0	SP INSTITUTION CONTROL OF THE STREET	d. STREET ADDRESS E. Boltsmore ST	e. IS RESIDENCE ON A FARM? YES NO
	NAME OF DECEASED (Type or print) CECELYC Middle	MILLER 4. DATE OF DEATH SEAT.	Day Year 6
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE of BIRTH - 1896 P. AGE (In years lost withday) Months Months	1 YEAR IF UNDER 24 HI Days Hours Min
	10a. USUAL OCCUPATION (Give kind af wark dane 10b. KIND OF BUSINESS OR INDI- dating most at working life eyes if retired)	Unknown	ZEN OF WHAT COUNTR Unknown
1	13. FATHER'S NAME MONKINGUL	14. MOTHER'S MAIDEN NAME MOUNT	(
/	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. (If yes, give wor or dotes of service)	Sufflosh 40 Records, Syk	enselle, ill
	18. CAUSE OF DEATH [Enter anly one cause per line of (a), (b), apol(c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO CINE No. /cle	Vascular acerdent	INTERVAL BETWEEN ONSET AND DEATH
	Canditions, if any, which gave rise to immediate cause (a), stating the underly lying cause lost. (b) Atleate OUE TO Conditions, if any, which gave rise to immediate (b) OUE TO Conditions, if any, which gave rise to immediate (c)	a Artenio selevotos	yeary
	PANII, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU	wansid type	PERFORMED?
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ED. (Enter noture of injury in Pajn 1 of Port 11 of item 18.)	
	20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED to Mark at while of wark at work at	LACE OF INJURY (Home, farm, 20f. (City or tawn) actory, street, affice bldg., etc.)	County) (Sta
	21. I certify that (this hospital) attended the deceased from saw the deceased alive on 1900 and that	death occurred at LM, from the couses and on the	2.9hat W (we) lo
	20. SIGNATURE KONSTRUCTURE Meber	M.D. ATTENDING MED. STAFF DIRECTOR PHYS.	22b. DATE SIGN
	22c. PHYSICIAN'S ONSTANTIN NEBER	11 Oak St. Sy Kestille, u	larylan
	23g. BURIAL, CREMATION, 234 DATE THEREOF 23c. NAME OF CEMETERY (BENDVAL (Specify) LEPT/4/60 OVER-SA	alon Baltemas	(State)
	24 FUNERAL DIRECTOR'S SIGNATURE DALC ADDRESS	250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIG	

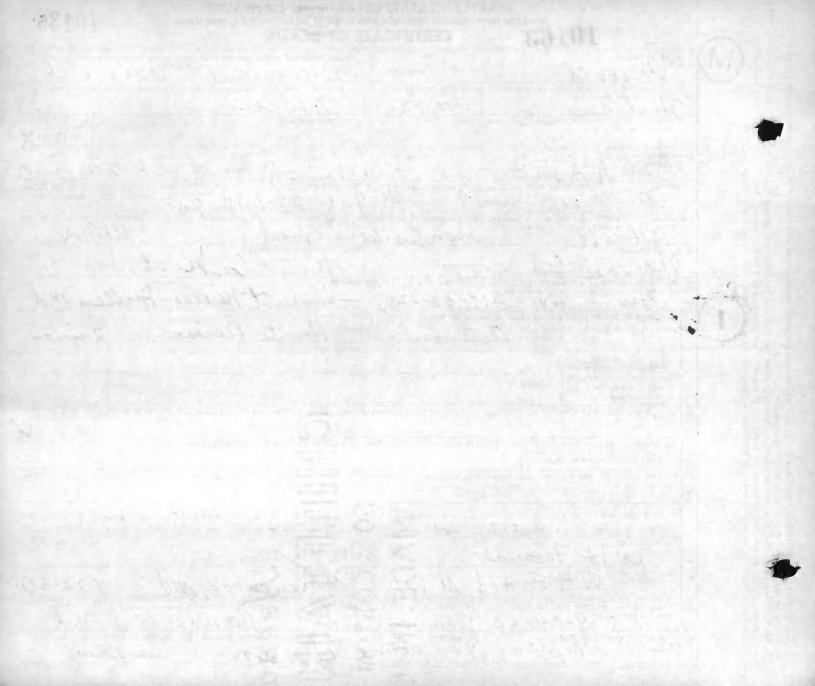


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 111100

10135

1	TATA9	CERTIFICA	IL OI DEATH	
)	1. PLACE OF DEATH o. COUNTY	MARYLAND	2. USUAL RESIDENCE (Where deceased lived o. STATE	b. COUNTY CLUMBER OF THE COUNTY CLUBBER OF T
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate lin	nits, write RURAL and give nearest tawn)
	d. NAME OF HOSPITAL (If not in hospitol, give street of OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES NO
	3. NAME OF DECEASED (Type or print) A T L	Middle	MILLER DEATH	Leph 22 1960
	S. SEX 6. COLOR OR RACE 7. MARRI WIDOWE	4	guly 27-1885	t birthday) Months Days Hours Min.
1	10o. USUAL OCCUPATION (Give kind of work dane 10b. I during most of warking life, even if retired)	Own Local	SYRY 11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	13. EATHER'S NAME Garre	tt-	14. MOTHER'S MAIDEN NAME Matilla	Resh.
1	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. (Yes, no, or unknown) (If yes, give was or dottes of service)	SOCIAL SECURITY NO. 17.11	- Everitt Mil	les-Milley md
)	18. CAUSE OF DEATH [Enter only one couse per lin PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO	teresland	tic Heart Res	interval between onset and death agree
	Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u>			
	Iying cause last. (c)	ONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CON	IDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES \(\sum \text{NO} \) NO \(\sum \text{NO} \)
		RIBE HOW INJURY OCCURRE	D. (Enter noture of injury in Part I ar Port II of	item 18.)
	20c. TIME OF INJURY Month, Day, Yeor While of work	Nat while fa	ACE OF INJURY (Home, farm, ctary, street, affice bldg., etc.)	wn) (County) (State)
	21. I certify that (I) (this hospital) attend saw the deceased alive an anti-7			1960, that (I) (we) last causes and an the date stated above.
	220. SIGNATURE WIX Fround			AFF SIGNED YS.
	22c. PHYSICIAN'S NAME (Type) WHFOAT	L M.D.	MANCHES ter	Md 9-22-60
	230. BURIAL, CREMATION, 23b. DATE THEREOF SEMOVAL (Specify) 9-24-60	23c. NAME OF CEMETERY C	CLA CREMATORY 23d. LOCATION	City, town, or caunty) (State)
	24. EURERAL DIRECTOR'S SIGNATURE TO CL	It auchter	A THE SEP 2 6 '60	25b. REGISTRAR'S SIGNATURE



ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

O FUNER page he 15M 9/5S

23. FUNERAL DIRECTOR'S SIGNATURE

ST SEAMILIAN STATE CONTRACTOR OF HEALTH STATE OF THE STATE OF 7 and process of the contract of the contract of the contract of the contract of

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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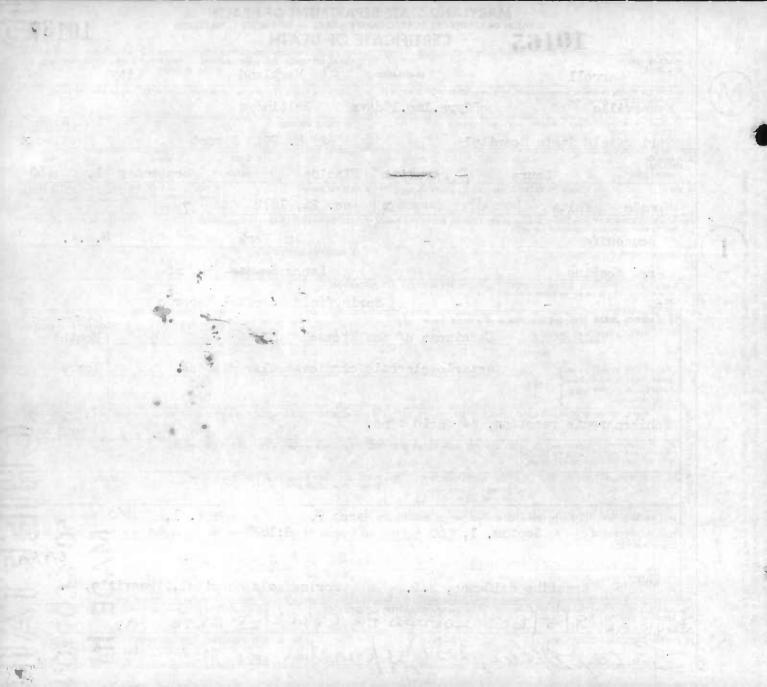
The law requires that the haspital or attending physician.

Funeral Directors: After this certificate has been signed by the attending physician and campletely filled in the page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and the State Board of Health prior to burial, cremation, or remayal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

10	E	10	ā.
VR 15	A	9/	(4)

		7				_				
1. PLACE OF DEATH o. COUNTY Ca	rroll		MARY	LAND	2. USUAL RESIDENCE (WHO O. STATE Mary		l lived. If institution b. COUNTY	City	before admi	ssion)
b. CITY OR TOWN RURAL and give Sykesvil	(If outside corporate limi negrest lown) 10	ls, write	c. LENGTH OF STAY 32yrs.lmo.	_	c. CITY OR TOWN (IF o		rate limits, write RI	URAL ond giv	ve nearest tov	vn)
OR INSTITUTION	eld State H				d. STREET ADDRESS 628 E. 29	9th St	reet		ON	A FARM?
3. NAME OF DECEASED (Type or print)	Fii Laur		Middle	Photo:	Placide	4. DATE OF DEATH	Mon Septe	_	Day 1,	Year 1960
s. sex Female	6. COLOR OR RACE White	7. MARR	NEVER MARRIED DIVORCE		Dec. 25, 18		9. AGE (In years last birthdoy) 87 yrs.	-	YEAR IF UND	-
Housev	rking life, even if retired	done 10b.	KIND OF BUSINESS O	R INDUS	RY 11. BIRTHPLACE (Stote New 1	York	ountry)		U.S.A.	
13. FATHER'S NAME Fred Mc	ahine				Laura S		NUSS			
	ER IN U. S. ARMED FOR Ilf yes, give war or dates of s		SOCIAL SECURITY NO		ringfield Ho		Records	ress		
Conditions, if gove rise to cause (a), stating lying cause last	immediate DUE TO) A:	CONTRIBUTING TO DE	rotic	cardiovascu			EN IN PART	Years	3
200. ACCIDENT W	'AS UNDERLYING G CAUSE OF DEATH Y MEDICAL EXAMINER)				. (Enter noture of injury in	Part I or Part	t II of item 18.)	0	YES] ио []
20c. TIME OF INJU Hour o. m. p. m.	RY Month, Day, Ye	While	NJURY OCCURRED Nat while k ot work		CE OF INJURY (Home, form ory, street, office bldg., etc		or town)	(Co	ounty)	(Stote
21. I certify th	at (I) (this haspital ased alive an Ser	clei		that de	larch 7, 19. eath accurred a2:1	∂PM rom ED. RECTOR □	STAFF PHYS.	d an the	dote stote	d above
23a. BURIAL, CREMATI REMOVAL (Specification of the control of the	951	ller	23c. NAME OF CEMIL LOUDP ADDRESS 2334		IKI CEM,	D BY REGIST	PALTO: RAR 25b. REGIS	STRAR'S SIGN	NATURE : 4	ate)



ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS - BALTIMORE 1, MARYLAND

10166

CERTIFICATE OF DEATH

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$\overline{}$							
1. F	PLACE OF DEATH D. COUNTY	MARYLAND	2. USUAL RESIDENCE (WHO o. STATE	here deceased lived. If instit b. COUN		ore admission)	
ŀ	CITY OR TOWN (If outside corporate limits, write RURAL and give neatest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF o	outside corporate limits, write	RURAL ond give no	earest town)	
(J. NAME OF HOSPITAL (If nat in haspital, give stree OR INSTRUTION	t address)	d. STREET ADDRESS	2 nd ave.		e. IS RESIDENCE ON A FARM? YES NO	
1	NAME OF SECASED Type or print) GERTRUL	Middle E	Pook F	4. DATE OF DEATH	Hopth 30	Day Year 1960	
5. 9	6. COLOR OR RACE 7. MAI	RRIED NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH Offil 13, 18	9. AGE (In year last birthday	Months Days	R IF UNDER 24 HRS Hours Min.	
10a	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stote	ar fareign country)	12. CITIZEN C	S. A.	
13.	FATHER'S NAME William A Alm	iples	14. MOTHER'S MAIDEN N	NAME . E. Ahor	wler)		
	WAS DECEASED EVER IN U. S. ARMED FORCES? I. no. or unknown) (If yes, give war or dates of service)	SOCIAL SECURITY NO. 17.1	NFORMANT ES MALLE OLI	ifton - ofin	Resulle	med.	
7	Conditions, if ony, which gave rise to immediate couse (o), stating the underlying couse lost. (b) GEN DUE TO		LEROSIS and	SEASE with	ARDITIS		
ICATION	PART II. OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERMI	INAL DISEASE CONDITION	GIVEN IN PART 1(a)	PERFORMED? YES NO	
CERTIF	20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	SCRIBE HOW INJURY OCCURRE	D. (Enter nature af injury in	Part I or Port II of item 1B.)			
MEDICAL	Haur o. m. Whil	6.	ACE OF INJURY (Home, farm actory, street, office bldg., etc		(Caunty	(Stote	
	21.1 certify that (1) (this haspital) attended the deceased fram. 1935						
	22c. PHYSICIAN'S	. m.D.		ED. STAFF PHYS.		22b. DATE SIGNED	
	NAME (Type) Wm. H. Lawson,	Jr., M.D.	Syke	esville-2, Ma	ryland		
	BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 10-2-60	Time of	OR CREMATORY	23d. LOCATION (City, tow	Carroll	(Stote)	
24.	FUNERAL DIRECTOR'S SIGNATURE	- ADDRESS	250. REC'	/	GISTRAR'S SIGNATI	UKE.	

TO HOSPITA VR A1S (4) 1SM 9/59 BRANCED BYALKED EN THE TOP INT

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2) C. O. App.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1016 CERTIFICATE OF DEATH

1	()	1	3	3	
J.	U	-		4,	

	arroll		MARYLA	ND	2. USUAL RESIDENCE (W o. STATE Mary		d lived. If institut b. COUNTY		ce before admissi 1timore	ion)
b. CITY OR TOWN (If RURAL and give ne	outside corporate limits arest town)	, write	c. LENGTH OF STAY IN	1b	c. CITY OR TOWN (If	outside corpo	rote limits, write l	RURAL ond g	give nearest town)
Sykesville	3	1	Oyrs.7mos.1	day	Relay	THE STATE OF	0:	3X-2	03X-	2
d. NAME OF HOSPITA	AL (If not in hospitol, gi	ve street a	ddress)		d. STREET ADDRESS				e. IS RES	DENCE FARM?
Springfie!	Ld State Ho	spita	1		1540 Rol	ling F	load			NO 📑
3. NAME OF DECEASED	First		Middle		Last	4. DATE OF	Ma		/	/ear
(Type or print)	Jo		Ingram		Prince	DEATH	Sept	cember		9 60
5. SEX	6. COLOR OR RACE	7. MARRIE	DEVER MARRIED	□ B	DATE OF BIRTH		9. AGE (In years lost birthdoy)	Months	Days Hours	
Male	White	WIDOWED	DIVORCED [January 13,	1896	64 yrs		bays Hours	Min.
10a. USUAL OCCUPATIO	N (Give kind of wark ding life, even if retired)	ne 10b. K	IND OF BUSINESS OR I	NDUST	RY 11. BIRTHPLACE (Stote	or foreign c	ountry)	12. CITI:	ZEN OF WHAT C	OUNTRY
Florist	ing me, even it remed)		_		Marvla	nd			U.S.A.	
13. FATHER'S NAME			mark the first		14. MOTHER'S MAIDEN					
Edmund G.	Prince				Martha Vi	rginia	Lyons			
15. WAS DECEASED EVER			OCIAL SECURITY NO.	17. INF	ORMANT		Add	dress		
(Yes. no. or unknown)	If yes, give war or dates of ser	vice)	•••	S	pringfield H	ospita	1 Record	is		
	18. CAUSE OF DEATH [Enter anly ane cause per line far (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Arterioscleratic heart disease Years									
gove rise to in cause (a), stating (lying couse lost.	Conditions, if ony, which gove rise to immediate cause (a), stating the underlying couse lost. DUE TO (b) Generalized arteriosclerosis DUE TO (c)				E CONDITION GI	VEN IN PART	PERFO			
200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESCR	RIBE HOW INJURY OCC	URRED.	(Enter nature of injury in	Part I or Par	t II of item 18.)			
20c. TIME OF INJURY Haur o. m. p. m.	Y Month, Doy, Year	While of work	_ Not while _		CE OF INJURY (Home, farr ery, street, office bldg., etc		ar town)	(0	County)	(Stote
21. I certify that (I) (this hospital) attended the deceased from 3/7/55 19 to Sept. 2,, 1960, that (I) (we) last sow the deceased alive on Sept. 1, 1960, and that death accurred of 124Mrom the causes and on the date stated obave.										
220. SIGNATURE	quatrii.	ceel	ampo		D. ATTENDING MPHYS.	IED.	STAFF PHYS.			SIGNED
22c. PHYSICIAN'S NAME (Type)	Agustin	delCa	ampo, M.D.		Springfie	ld Hos	spital, S	ykesv	ille, M	d.
23a. BURIAL, CREMATIO REMOVAL (Specify) Burial	9/5/1960		23c. NAME OF CEMETE Prospect				TION (City, town,	or county)	(State	e)
24, FUNERAL DIRECTOR'S	SIGNATURE STONE	ons	ADDRESS C.ATON	SY	ILLE 250. REC	D BY REGIST		ISTRAR'S SIC		

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	and the second second	10404-	

TO HOSPITAL STEEDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 haurs after death. Page 4 may be reld, to by the hospital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 shauld be filed with the registrar priar to burial, crematian, or remayal, and in any event within 72 hour after death.

VS A15 (4) 15M 9/5B Reg. Dist. No.

	TATOR				Reg. Dist.	No.
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE	(Where deceased lived. If ins	stitutian: Residence l	befare admission)
	arroll	MARYLAND	a. STATE Mary	land b. col	ONTYCarrol	.1
b. CITY OR TOWN RURAL and give	(If autside carporate limits, w	rite c. LENGTH OF STAY IN 16		(If autside carporate limits, w	rite RURAL and give	nearest tawn)
Mt. Ai	TV	20 yrs.	Mt.	Airy		
	PITAL (If not in hospital, give s		d. STREET ADDRES			e. IS RESIDENCE ON A FARM? YES NO
NAME OF	First	Middle	Last	4. DATE	Month	Day Year
(Type ar print)	ELSIE		BINSON	OF DEATH SE	127	Day Year 19 GC
. SEX	6. COLOR OR RACE 7.	MARRIED 🌃 NEVER MARRIED 🗌	B. DATE OF BIRTH	9. AGE (In y		EAR IF UNDER 24 HR
female	white wit	DOWED DIVORCED	Aug. 25	, 1896 64	yrs. Manths Da	ys Hours Min.
Oa. USUAL OCCUPAT during mast of we hous	TION (Give kind of work done orking life, even if retired) EWITE	106. KIND OF BUSINESS OR IND		tate ar fareign country) Virginia	12. CITIZEN	U.S.
3. FATHER'S NAME	3.19 12.11 1.1		14. MOTHER'S MAIDE	N NAME		
	George He	drick	Mary C.	Richardson		
S. WAS DECEASED ET	VER IN U. S. ARMED FORCES?	16. SOCIAL SECURITY NO.	INFORMANT		Address	
(Yes, no, or unknown)	(If yes, give wor or dates of service)		Mr. Guy A.	Robinson	same	
Conditions, if gave rise to cause (a), statin lying cause las	immediate DUE TO	DNS CONTRIBUTING TO DEATH BI	IT NOT RELATED TO THE TE		N GIVEN IN PART 1((a) 19. WAS AUTOPS' PERFORMED? YES NO
OR CONTRIBUTION	FY MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCUR	RED. (Enter nature af injury	in Part I or Part II of item 18	3.)	
20c. TIME OF INJU Haur a. m p. m	1. 10 V		PLACE OF INJURY (Hame, actary, street, affice bldg.,		(Cau	nty) (State
alive an ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)				F.M. from the cause: ADDRESS (Street, city or to Sa Main 1 to Airy, 1	s and an the d	saw the decease late stated above DATE SIGNE
20. BURIAL, CREMAT REMOVAL (Specif BURIAL	9-4-1960	22c. NAME OF CEMETERY Pine Gro		Mt. Airy	, Md.	(State)
3. FUNERAL DIRECTO		ADDRESS	24a. F	REC'D BY REGISTRAR 24b.	REGISTRAR'S SIGNA	ATURE
C. M.	Waltz, W	infield, Md.	DATE	SEP 6 '60	arthur 8	House

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	to allow the contract of	.ecv 05	rila en
	DES S. MALT ST.		. To Athir B and
	40. EU		
	Aug. 25, 1896 61.		resident a secon
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	nosbymichi C yash	The State of	Granton .
	it. Day a. Robinson		
		And the second	
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10141

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CAPROLL MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE M. A. O. Y. A. J.) b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)
MEADOW VI EN Westpruster RD 34	COB BALTIMORE, 18
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION MEADOWY LEW CONUMES AT	d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
HEAD WITH CONCINES	2/65 ACAMEDA BLUD. YES NO BE
3. NAME OF DECEASED (Type or print) AURA AMELIA	SHUPP DEATH SEPT 3 1960
S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lost birthdoy) Months Days Hours Min.
FEMALE WHOTE WIDOWED DIVORCED	\$ \tag{yrs.}
10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRIES OF WORKING LIFE even if retired) OF STORE	STRY 11. BIRTHPLACE (Stole or fareign country) 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
LOVES SCHUPP	CAROLINE BRANNG
(Yes, no. or unknown) (If yes, give wor or dates of service)	NFORMANT Address Address
(VO - XV)	& MALA TUNKNAM, GRUGA WALMANUN
1B. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRA	THROM BOSIS
DUE TO	
Conditions, if any, which) (b) CARCINOMA	OF BREAST WITH METISTESS
gove rise to immediate coese (o), stating the under-	
lying cause lost. (c) TO S	PINE & LUNGS 18 MOS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	PERFORMED? YES NO
206. ACCIDENT WAS UNDERLYING A 206. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	D. (Enter nature of injury in Port I or Port II of item 18.)
ZOc. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED for Hour o. m. 19 While Not while of work 10 twork 10 two	ACE OF INJURY (Home, farm, 20f. (City or tawn) (County) (State) ctary, street, affice bldg., etc.)
21. I certify that I attended the deceased from.	5, 1960, to 9 13, 1960, that I last saw the deceased
	accurred at 830 A. M. fram the causes and an the date stated abave.
and a later of the second	ADDRESS (Street, city or town, stote) DATE SIGNED
SIGNATURE WALLEM J. SCHOOL	MD 19 RIDGE RD 4/2/6
PHYSICIAN'S WILLIAM L. STEWAR	T WESTHINSTER, MD
220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OF	R CREMATORY 22d. LOCATION (City, town, or county) (State)
Bring Sept, 6,60 Ballimore	Complexed Ballanesse (Stoje)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	240 REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
X. 2. Myer A. Metmuster.	DATE SEP 6 '60 arling d. Trans

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A No. of Parts and Parts a		
and the same of th		

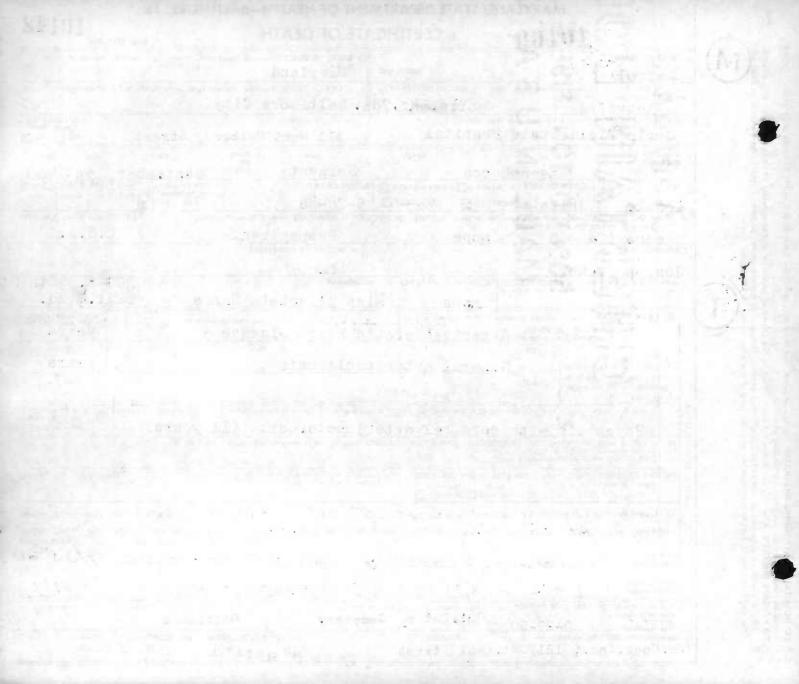
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH 10169 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY b. COUNTY MARYLAND Carroll b. CITY OR TOWN (If autside carporate limits, write c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) RURAL and give negrest town) 8Yrs. 5Mo.7da. Baltimore City Sykesville d. NAME OF HOSPITAL (If not in hospital, give street oddress)
Springfield State Hospital d. STREET ADDRESS 4. DATE NAME OF Middle (Type or print) Mae Rebecca Sergent DEATH 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH DIVORCED | 5-28-86 WIDOWED T Female 10a. USUAL OCCUPATION (Give kind of wark dane 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign cauntry) during most of working life, even if retired) Pennsylvania Housewife none 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

e. IS RESIDENCE ON A FARM? 111 West Mulberry Street YES NO X Year September 1960 IF UNDER 1 YEAR IF UNDER 24 HRS 9. AGE (In years lost birthdoy) Months Days 12. CITIZEN OF WHAT COUNTRY? U.S.A. Anna Joseph Stoker INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO es, give war or dates of service) Balt .. Miss Elizabeth Hanna none no 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL SETWEEN years PART I. DEATH WAS CAUSED 8Y: Arteriosclerotic Heart Disease DUF TO General Arteriosclerosis years Conditions, if any, which gave rise to immediate DUE TO couse (a), stoting the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? Psychosis with cerebral arteriosclerosis YES NO T 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f, (City or town) (County) (Stote) factory, street, affice bldg., etc.) Haur a. m. While Not while at work at wark p. m 1960, to Sept 25, 196ahat I last saw the deceased 21. I certify that I attended the deceased fram Sept. , and that death accurred at 8:20PM, from the causes and an the date stated above. alive an ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL Springfield State Hospital SIGNATURE PHYSICIAN'S G. KOUKOULAS Sykesville, Maryland NAME (Type) 22a. SURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, ar county) (State) REMOVAL (Specify) St. Peters Cemetery Baltimore BURIAL 9-29-60 23. FUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE 24g. REC'D BY REGISTRAR Orthur S. Kraus Wm. Cook, Inc., 1217 St. Paul Street DATE SEP 2 8 '60

10142

Rea. Dist. No

VS A15 (4) 1SM 9/58



	10135	CERTIFICATE OF	DEATH	10143 Reg. Dist. No.
1. PLACE OF DE a. COUNTY	Parroll	MARYLAND 2. USUAL R		. If institution: Residence before admission) pr COUNTY
RURAL and	aive nearest town)	504m? All	OR TOWN (If pyside corporate lin	mits, write RURAL and give nearest town).
d. NAME OF OR INSTITU	HOSPITAL (If not in hospital, give street or ITION)	d. STREE	19W.A	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print	WILLIA	M A. SHAE	Lost 4. DATE OF DEATH	SEPT / 1960
5. SEX	6. COLOR OR RACE 7. MARRIE		29 1882 7	E (In years birthday) Wanths Doys Hours Min.
	CUPATION (Give kind of work dane 10b. K of working life, even if retired)	IND OF BUSINESS OR INDUSTRY 11. BIRT	HPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTR
13. FATHER'S NA	me Shall	Her 21. MOTH	ER'S MAIDEN NAME	mi Buch
15. WAS DECEAS	EDEVER IN U. S. ARMED FORCES? 16/5 (If yes, give wor or dates of service)	CIAL SECURITY NO. INFORMANT	A. Shaeller	Address Grun St
	OF DEATH [Enter only one cause per line 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	for (a), (b), and (c).]	nhano.	INTERVAL SETWEEN ONSET AND DEATH
Condition	DUE TO s, if ony, which) (b)	Vorteren tooker	isclevous	16 ngin
	to immediate DUE TO			
PART	II. OTHER SIGNIFICANT CONDITIONS CO	DNTRIBUTING TO DEATH BUT NOT RELATED) TO THE TERMINAL DISEASE CON	DITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED? YES NO (
OR CONTRIB	NT WAS UNDERLYING 20b. DESCI BUTING CAUSE OF DEATH NOTIFY MEDICAL EXAMINER)	RIBE HOW INJURY OCCURRED. (Enter natu	re af injury in Part I or Port II of	item 18.)
20c. TIME OF		1401 WILLIE	RY (Home, farm, 20f. (City ar tov office bldg., etc.)	wn) (County) (Stat
21. I cert	ify that I attended the decease	-1	gt A M from the c	, 1966, that I last saw the decease
ACTUAL SIGNATURE	Sarlus Cho	PRO MAD. 8	ADDRESS (Street, c	
PHYSICIAN'		chepko		
220. BURIAL, CRE NEMOVAL (S		22c. NAME OF CEMETERY OF CREMATOR	melly hard	City, town, or county) (State)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TOURS CHINECATE OF BEATH Love of the Court Charles Charles the state of the state of the contract of the state of th The second of th TO LEAD OF THE PROPERTY OF THE PARTY OF THE The state of the s Carl Market Brown Charles and Market Carles and Carles The second of th Parks and the state of District the first of the state of the state

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ARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 136 CERTIFICATE OF DEATH

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	neg. 5/31, 170.
1.	PLACE OF DEATH a. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) b. COUNTY b. COUNTY Carroll
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) S Years RURAL ond give nearest town)
	d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION 3/1// 4. STREET ADDRESS O. STREET ADDRESS O. A FARM? YES NO
	NAME OF DECEASED (Type or print) NAME OF DECEASED (Type or print) NAME OF DECEASED (Type or print) NAME OF DEATH SEPT. 28 1%00
S.	SEX COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH WIDOWED DIVORCED DIVORCED MAY 13, 1885 9. AGE (In yeors lost birthday) Months Days Hours Min.
2	b, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) during most of working life, even if relired) HOUSEWIFE 12. CITIZEN OF WHAT COUNTRY?
13	CHARLES THOMAS SHARP LAURA HAINES
1S (Y	. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (If yes, give wor or dates of service)
	PART I. DEATH WAS CAUSED BY: DUE TO Canditians, if any, which gove rise to immediate codise (o), stoting the underlying cause last. (c) INTERVAL BETWEEN ONSET AND DEATH THIN OM BOSIS INTERVAL BETWEEN ONSET AND DEATH THIN OM BOSIS DUE TO DUE TO (c)
CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO. 12
MEDICAL	20c. TIME OF INJURY Month, Doy, Year Haur a. m. p. m. 19 20d. INJURY OCCURRED While Not while at work of wo
	21. I certify that I attended the deceased fram. DEC., 1959, to SEPT-28, 1960, that I last saw the deceased alive an SEPT-28, 1960, and that death accurred at 5 P. M. fram the causes and an the date stated abave. ACTUAL SIGNATURE Nelliam L. SERVART M.D. 19 RID GE RD 9/28/60 PHYSICIAN'S NAME (Type) NILLIAM L. STEWART MID WESTMINSTER, MD
27	REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, tawn, or county) (Stote)
23	FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS 240, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATEP 3 0 '60 Oxiling 8 through

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New Street, March 1997		
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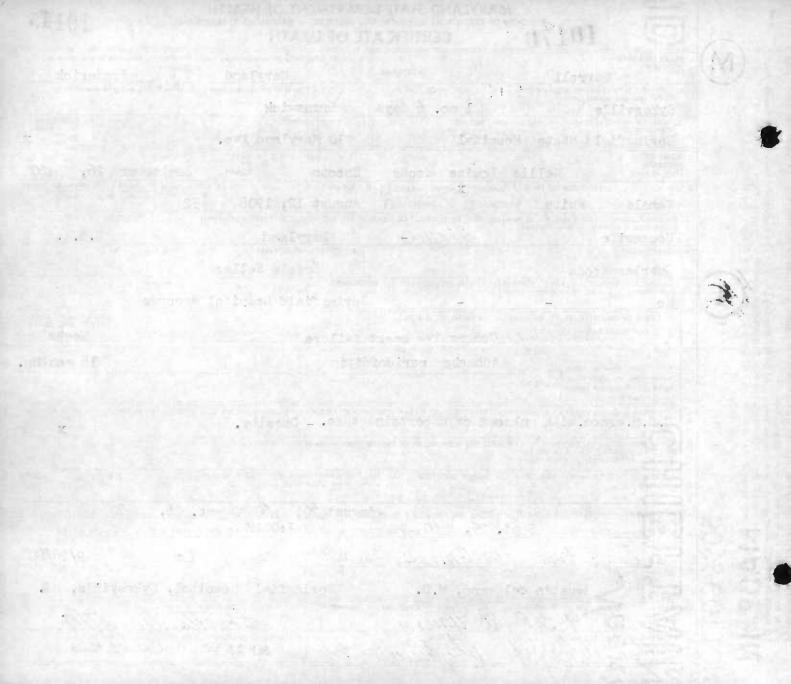
, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO HOSPITA

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

)	1. PLACE OF DEATH o. COUNTY Carroll	MARYLA	II 7 5	AL RESIDENCE (WITATE	where deceased	lived. If institution b. COUNTY		ederick		
	b. CITY OR TOWN (If autside carparate limits, RURAL and give nearest lawn)	, write c. LENGTH OF STAY IN	1 1b c. C	c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn)						
	Sykesville	1 mo. 6 da	ys	Brunswick						
	d. NAME OF HOSPITAL (If not in haspital, give OR INSTITUTION	e street address)	d. 9	TREET ADDRESS	T	4.0	200	e. IS RES	FARM?	
	Springfield State H	1	O Maryla	nd Ave.		33.		NO 📆		
	3. NAME OF First	1	Last 4. DATE Manth					Year		
	(Type or print) Nellie		ots	DEATH	Septe	ember	26,	1960		
	S. SEX 6. COLOR OR RACE 7	MARRIED NEVER MARRIED	8. DATE	OF BIRTH	9	9. AGE (In years last birthday)		YEAR IF UND		
		WIDOWED DIVORCED		ust 12,		52 yrs.	Manths [Days Haurs	Min.	
	10a. USUAL OCCUPATION (Give kind of work dar during most of working life, even if retired)	ine 10b. KIND OF BUSINESS OR	INDUSTRY 11.	BIRTHPLACE (State	e ar fareign ca	untry)	12. CITIZ	EN OF WHAT	OUNTRY?	
	Housewife	Stoule		Marylan	d			U.S.A.		
	13. FATHER'S NAME		14. M	OTHER'S MAIDEN	NAME					
	Charles Woods			Bessie	Keller					
1	15. WAS DECEASED EVER IN U. S. ARMED FORCE (Yes. no. or unknown) (If yes, give wor or dates of servi	ES? 16. SOCIAL SECURITY NO.	17. INFORMAL	IT		Addr	ess	19-12-1		
1	No -	-	Spri	ngfield	Hospita	al Record	is			
	1B. CAUSE OF DEATH [Enter only one cause PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Congestive he						INTERVAL BETWEEN ONSET AND DEATH Weeks		
	Candilions, if any, which gave rise to immediate cause (a), stating the <u>under-lying cause last.</u> Compart II. OTHER SIGNIFICANT CONDITIONS	TIONS CONTRIBUTING TO DEATH	carditi	ATED TO THE TERM	AINAL DISEASE	CONDITION GIV	EN IN PART	18 mo	AUTOPSY	
	PART II. OTHER SIGNIFICANT CONDITION OF C.B.S. assoc.with unknown or contributing and constrained associated and contributing and constrained associated a								NO [
-		06. DESCRIBE HOW INJURY OCC	LUKKED. (Enter	nature at injury in	Part I ar Part	If at item 18.)				
	V 20c. TIME OF INJURY Manth, Day, Year Haur a. m. 19	20d. INJURY OCCURRED While Nat while at wark at wark		NJURY (Hame, fare et, affice bldg., et		ar tawn)	(Co	iunty)	(State)	
	21. I certify that (I) (this haspital) of saw the deceased alive an Sep	attended the deceased from 15 19 60 and the	om Augus	t 20, 19	00 taSe	he couses co	, 1960	_, that (I) (we) last	
	22a. SIGNATURE	Let Campe		TENDING A	MED.	STAFF PHYS.	o an me	22	b. DATE	
	22c. PHYSICIAN'S NAME (Type) Agustin de	elCampo, M.D.		ADDRESS Springfi			Sykesv			
	23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)	-60 UMON	ery or crema	TORY	23d. LOCATI	ON (City, town, o	ir county)	7/a	(e)	
	24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS ADDRESSE	Ile, m	25a. REC	SEP 2 8	AR 2Sb. REGIS	TRAR'S SIGN	11	Ī.	



VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1	1	1	4	6
1	77	1	-dL	U

1	1. PLACE OF DEATH o. COUNTY Carroll	MARYLANI	2. USUAL RESIDENCE (Where deceased lived. If institution: Resid o. STATE Maryland b. COUNTY Fre	ederick
	b. CITY OR TOWN (If outside corporate lim RURAL and give nearest lown) Sykesville	nits, write c. LENGTH OF STAY IN 1	b c. CITY OR TOWN (If outside corporate limits, write RURAL on Middle Town.	d give nearest town)
5	d. NAME OF HOSPITAL (If not in hospital, OR INSTITUTION Springfield State H		d. STREET ADDRESS None	e. IS RESIDENCE ON A FARM? YES NO
	3. NAME OF FIDECEASED (Type or print) Edw	irst Middle Vard Frank	Lost 4. DATE Month OF Thompson DEATH Septembe	Day Year 22. 19 60
	5. SEX 6. COLOR OR RACE White	7. MARRIED NEVER MARRIED WIDOWED DIVORCED	B. DATE OF BIRTH 9. AGE (In years If UND last birthday) Manths	ER 1 YEAR IF UNDER 24 HRS
1	10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired Carpenter 13. FATHER'S NAME	done 10b. KIND OF BUSINESS OR IN	IDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. C	U.S.A.
1	Unknown- JAMES	H. THOMPSON	Unknown OCTAVIA	CAMBELL
	15. WAS DECEASED EVER IN U. S. ARMED FOI (Yes, no, or unknown) (If yes, give war or dates of		Springfield Hospital Records	
	PART I. DEATH Enter only one of PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (I DUE TO Conditions, if ony, which gove rise to immediate couse (o), stating the under-	Terminal brone Arteriosclero	chopneumonia tic cardiovascular disease	INTERVAL BETWEEN ONSET AND DEATH Days
1	lying couse lost. C. B. S. associated w	20b. DESCRIBE HOW INJURY OCCUI	BUT NOT RELATED TO THETERMINAL DISEASE CONDITION GIVEN IN P. SIS. RRED. (Enter noture of injury in Part I or Port II of item 18.)	ART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, You Hour a.m. 19 p. m.		PLACE OF INJURY (Hame, farm, 20f. (City or town) foclory, street, office bldg., etc.)	(County) (Stote
	21. I certify that (I) (this haspital saw the deceased alive an Second street 22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) Agustin deceased alive an Second street alive and second street and	lel Compo.	m. Sept. 13, 1960, to Sept. 22, 19 at death accurred a 1:15P. From the causes and on to M.D. ATTENDING MED. STAFF PHYS. DIRECTOR PHYS. 22d. ADDRESS Springfield Hospital, Sykes	he date stated above 22b. DATE 9/22/60
1	230. BURIAL, CREMATION, REMOVAL (Specify) 24. FUNERAL DIRECTOR'S SIGNATURE	23c. NAME OF CEMETER'S 1960 BIROVVIVSV ADDRESS DOON SIDE	Y OR CREMATORY 1415 CEMETRY BROWNSVILLE W 250. REC'D BY REGISTRAR 25b. REGISTRAR'S DATEOCT 3 '60 CALLAN S	IASH COUNT

foreigned many brokening the reference at the first section and the the spirit spirit spirit

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

11117	GERTII TO			
PLACE OF DEATH Carroll	MARYLAND	2. USUAL RESIDENCE (W. o. STATE Mary		ution: Residence before admission)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton	c. LENGTH OF STAY IN 1b		outside corporate limits, write	e RURAL and give nearest town)
d. NAME OF HOSPITAL (If not in hospital, give street or INSTITUTION THEN TYTON State Ho	oddress) spital	d. STREET ADDRESS	. Carey Stree	e. IS RESIDENCE ON A FARM? YES NO
8. NAME OF First DECEASED (Type or print) Matthew	Middle	Towns		9 Doy Year 19 60
S. SEX 6. COLOR OR RACE 7. MARR Negro WIDOWE		8. DATE OF BIRTH 10-26-1909	9. AGE (In year lost birthdoy 50 yr	Months Days Hours Min.
	KIND OF BUSINESS OR INDU	Macon, l	N. C.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
3. FATHER'S NAME Washington Towns		Mattie		
(Yes, no. or unknown) I (If yes give war or dates of service)	30-03-6416	NFORMANT Matthew	Towns - Pat:	ddress ient
gove rise to immediate cause (a), stoting the <u>under-lying couse lost.</u> (b) DUE TO (c)	advanced bila			
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURRE	D. (Enter noture of injury in	Port I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year 20d. II Hour a. m. While p. m. 19 of wor	Not while fo	ACE OF INJURY (Home, for ctory, street, office bldg., etc		(County) (State)
21. I certify that (1) (this haspital) attends saw the deceased alive an Septe 1 220. SIGNATURE Cagains M. M.	5 19 60, and that	ATTENDING M	• MOrrom the causes	
22c. PHYSICIAN'S NAME (Type) Edgars M. Macu	alans, M.D.	22d. ADDRESS		ital, Henryton, M
230. BURTAL, CREMATION, REMOVAL (Specify) PURTAT. 24. FUNERAL DIRECTOR'S SIGNATURE	23 NAME OF CEMETERY C	CT CHILD	23d. LOCATION (City, 19wi	n, or county) (Stote) GISTRAR'S SIGNATURE
Chan's Fcoper	810 Carmel	TO MO DATE	1 9 '60	Orthur S. Kraus

Service Services and the service of s you below the state of the st The second of the Tolland Tance, M. V. nand pared of the same of the T. H. Louis W. School and B. C. St. THE RESIDENCE OF STREET

D HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital or attending physician.

D FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in the funeral director, page 3 should be detached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and a should be filed with the State Board of Health priar to burial, cremation, or remaval, and in any event, within 72 haurs after death.

TO HOSPITAL	moy be refo	TO FUNERAL	page 3 shou
VR 15	A	9/9	(4)

	10172	CERTIFICA	ATE OF DEATH			35 100		
1. PLACE OF DEATH o. COUNTY Carr	oll	MARYLAND	2. USUAL RESIDENCE (WI		b. COUNTY		efore admissington	V
b. CITY OR TOWN (I RURAL ond give no Sykesvil	f outside corporate limits, write earest town) 1e	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF o		te limits, write RI	URAL ond give	nearest town	2
OR INSTITUTION	AL (If not in hospitol, give street lead State Hospital)		d. STREET ADDRESS 722 Oak	Hill A	ve.			FARM?
3. NAME OF DECEASED (Type or print)	Jeanette		Wakefield	4. DATE OF DEATH	Mon Septe	mber :	25,	Year 1960
Female	White wind	ARRIED NEVER MARRIED TO DIVORCED DIVORCED	B. DATE OF BIRTH	72	AGE (In years last birthday) 88 yrs.	Months Da	ys Hours	Min.
Unknown	ON (Give kind of wark dane 1 king life, even if retired)	06. KIND OF BUSINESS OR IND	Unlenown	d.	ntry)		S.A.	OUNTRY?
13. FATHER'S NAME Unknown	eft. John El	akefield	Unknown	Varoler	ie offi	ario)		
	R IN U. S./ARMED FORCES? (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 17.	Springfield	Hospita	Addr Al Reco		i Oud	H
	ATH [Enter only one couse pe TH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Intestinal obs	truction				NTERVAL SE DNSET AND	DEATH
Conditions, if o gove rise to i couse (o), stoting lying cause lost.	mmediote (Gangrenous ing	uinal hernia,	right			3 day	3
	lerotic cardi	ovascular dise		INAL DISEASE C	CONDITION GIV	EN IN PART 1	a) 19. WAS PERFO YES X	ORMED?
	AS UNDERLYING (1) 20b. I	DESCRIBE HOW INJURY OCCURR	ED. (Enter noture of injury in	Part I or Port II	l of item 1B.)			
20c. TIME OF INJUR Hour o. m. p. m.	WI	H. INJURY OCCURRED 20e. File Nat while wark at wark	PLACE OF INJURY (Home, farm octory, street, office bldg., etc	n, 20f. (City o	r town)	(Cou	nty)	(State)
21. I certify that saw the decease		ended the deceased fram	9/23/60 19 death occurred at 1:1		25/60 ne couses an			
220. SIGNATURE	estin del	Compo	M.D. PHYS.	NED.	STAFF PHYS.		9/	b. DATE SIGNED 25/60
'22c. PHYSICIAN'S NAME (Type)	Agustin delCa	ampo, M.D.	22d. ADDRESS Springfiel	d Hospi	tal, Sy	kesvil	le, M _d	•
23a. BURIAL, CREMATIO REMOVAL (Speaify)	9-29-60	23c. NAME OF CENTERY	nie	Elle	ON (City) town,	ty,	ml).	łe)
24. FUNERAL DIRECTOR	S SIGNATURE	Dykesville	me 25a. REC	EP 28 8	R 25b. REGU	STRAR'S SIGN	TURE	

MUNICATE OF DEATH

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A.M. contribe attach

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

	PLACE OF DEATH	11		2. USUAL RESIDENCE (Wh			nce before admission)	
	(oa	rroll	MARYLAND	m	d'	o. COUNTY (Va	rece	
	b. CITY OR TOWN (If a RURAL and give near	outside corporate limits, write	c. LENGTH OF STAY IN 16	CITY OF TOWN (If 9	utside corporate lin	nits, write RURAL and	give nearest town)	
19	Pular Ol	whereintel	75 years	Tural.	de	Meswell	2,	
	d. NAME OF HOSPITAL	At nat in haspital, give street	address)	d. STREET ADORESS	1	0	e. IS RESIDENCE	CE
	OR INSTITUTION			Oklak	ma.	Troad.	YES NO	X
3.	NAME OF	First	Middle	Last	4. DATE	Month	Day Year	
	DECEASED (Type or print)	MAY	Mi	WARNER	OF DEATH	SEPT	6 196	O
S.	SEX M	6. COLOR OF RACE 7. MAR	RIED NEVER MARRIED	B. DATE OF BIRTH		E (In years IF UNDER	1 YEAR IF UNDER 24 H	
	Tille	White WIDOW		Sept. 3. 18	8/ 7	79 yrs.	Doys Hours Mi	in.
100	during most of working	(Give kind of work done 10b	KIND OF BUSINESS OR IND	JSTR 11. BIRTHPLACE (Stote	ar foreign country)	12.CIT	IZEN OF WHAT COUNT	TRY?
	William		ublic Vicicle	m mi	the state of the s	4	1. S. A.	
13.	FATHER'S NAME	1 1 4	. /	14. MOTHER'S MAIDEN N	IAME	01	41	
	Whiall	od. W	arner	Julianne	a (30)	person	ille	
		IN U. S. ARMED FORCES? 16.	SOCIAL SECURITY NO. 17.	NFORMANT		Address	1 11	
	nu	- 2	15-05-1986	Mrs Mana	2B.Wa	rner- Hy	dessible,	74
	18. CAUSE OF DEATH	H [Enter only one couse per l	ine for (a), (b), and (c).]		-		INTERVAL BETWEE	
	PART I. DEATH	H WAS CAUSED BY:	orner H	romhous, c	arlers	elerous	ONSET AND BEAT	
	420.	DUE TO			1 . ,		1955	
	Conditions, if ony		eneroly of	Carles	Laulter	۷.	70	
	gove rise to imr		1 1 -	- /	()		1 105	1
	lying couse lost.	(c) (d)	Merwelleste	e Ment de	esedul.		6 steps 6	30
CATION	PART II. OTHER	R SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERMI	NAL DISEASE CON	IDITION GIVEN IN PAI	RT 1(a) 19. WAS AUTO	PSY)?
CAT							YES NO	-
CERTIFI	200. ACCIDENT WAS	UNDERLYING 1 20b. DES	SCRIBE HOW INJURY OCCURE	ED. (Enter nature of injury in I	Part I or Port II of	item 1B.)		
	(IF EITHER, NOTIFY M	EDICAL EXAMINER)						
ICAL	20c. TIME OF INJURY Hour o. m.			LACE OF INJURY (Home, form octory, street, office bldg., etc.		vn) (County) (St	tote)
MEDI	p. m.	19 While of wo	Nat while	ociony, sinces, office biog., cic.				
	21. I certify that	(I) (this hospital) atten	ded the deceosed from	1955 19	. to 6 0	erk 16"	, that (I) (we)	last
	saw the deceased	P Ac	/.	death occurred at 2:35	Am from the	couses and on th	1111	
	220. SIGNATURE	1	2 2/ 2		,	Total on the	22b. DAT	
	1 Ha	evaring 6	e Hall	M.D. PHYS.	ED. STA	AFF YS.	7 Sent 6	NED
11	22c. PHYSICIAN'S NAME (Type)	1	11	22d. ADDRESS	,)- /		
V	HAME (Type)	OWAYD E.	Halb	Jest-	emll,	me.		
230	BURIAL, CREMATION,	236 DATE THEREOF	23c. NAME OF CEMETERY	OR GREMATORY	23d. LOCATION	City, town, or county)	(State)	-
	TOULUM (Specify)	7-4-60	Theo aabel	and	Mardyke	wille Par	roll lo m	N
24.	FUNERAL DIRECTOR'S	SIGNATURE CAL	ADDRESS AN	es //	D BY REGISTRAR	25b. REGISTRAR'S SI		-6-
1	nether Fr	. Halghir.	Rydisulle	my DATE SE	P 9 '60	Carilhan &	. Thank	1.1

ADMINISTRATE OF THE

funeral director,

ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after death. Page

MARYLAND STATE DEPARTMENT OF HEALTH

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		AND RECORDS — BALTIMORE 1, MARYLAND TE OF DEATH	10150
	PLACE OF DEATH O. COUNTY CARROLL CO, MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before o. STATE MARYLANDS. COUNTY BALT	admission)
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give near	est town)
	d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION BASLER RD home	MY 01100-01	IS RESIDENCE ON A FARM? YES NO X
-	NAME OF DECEASED (Type or print) EMMA CORA WE	Last 4. DATE Month Day OF DEATH SEPT.	Year 1960
S.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH AN. 3, 1886 9. AGE (In years last birthdoy) Manths Days	F UNDER 24 HRS. Hours Min.
100	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDU during mast of working life, even if retired)	JSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF V WARVLAWP US	WHAT COUNTRY?
3.	FATHER'S NAME WILLIAM RULL MANN	SARAH JANE MACKLEY	
1S. (Ye	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. II	FAMILY RECORDS	
	1B. CAUSE OF DEATH [Enter anly one couse per line far (a), (b), ond (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO	monhage (Recovent) INTER	T AND DEATH
	Conditions, if ony, which gove rise to immediate cause (o), stating the underlying couse lost. (b) DUE TO	relevous (generalized)	ins
CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	T NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19	. WAS AUTOPSY PERFORMED?
CERTIFI	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRE OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	ED. (Enter nature of injury in Part I ar Part II of item 18.)	
MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED to Mole to the Policy of Work of Work to the Policy	LACE OF INJURY (Home, form, octory, street, office bldg., etc.) (City or tawn) (County)	(Stote
	21. I certify that (I) (this hospital) attended the deceased fram saw the deceased alive an 7-14 1960, and that	death accurred at 42 M, from the causes and an the date	stated abave.
	220. SIGNATURE 1 1 1 7 - 7 1	M.D. ATTENDING MED. STAFF PHYS. MED. PHYS.	22b. DATE SIGNED
	22c. PHYSICIAN'S NAME (Type) W. H. FO AFD M.D.	MAMChrsterud 9-	17-60

may be reported.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 one page 3 shauld be detached for use as the burial-transit permit. TO HOSPITAL

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, ar county)

(State)

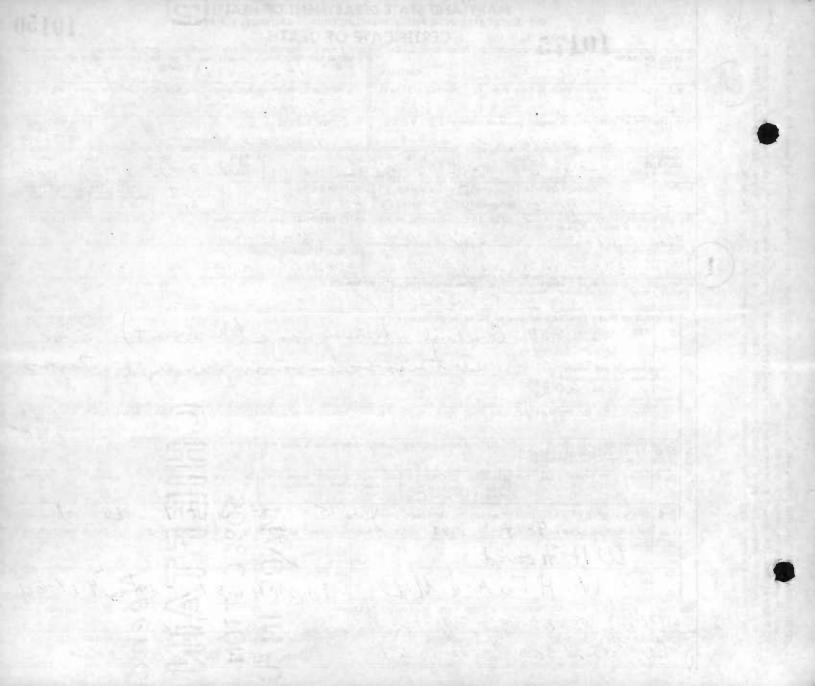
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS

250. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

SEP 21 '60

Challens S. Krous



1111	20	CERTIF	ICA	IE OF DEATH							
1. PLACE OF DEATH o. COUNTY Carroll	- COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) Sykesville c. LENGTH OF STAY IN 1b L1 mos. Baltimore 14				V O I	AL and give negrest town)						
d. NAME OF HOSPITAL (If not in hoor INSTITUTION Springfield St		eet address)		d. STREET ADDRESS 511 Ross	iter	Ave.			ESIDENCE A FARM?		
3. NAME OF DECEASED (Type or print)	First Mary	Middle H	leim	Unst Wheeler	4. DATE OF DEATH	Septe		Day 6,	Year 1960		
s. sex 6. color o		ARRIED NEVER MARRI		8. DATE OF BIRTH March 9, 187	7	9. AGE (In years last birthday) yrs.	IF UNDER Months	Days Hour	-		
10a. USUAL OCCUPATION (Give kind during most of warking life, even Seamstress:		0b. KIND OF BUSINESS C	R INDUS	Maryland	ar foreign c	ountry)	12.CIT	ZEN OF WHA			
13. FATHER'S NAME William H. Heim				14. MOTHER'S MAIDEN N. Anna Kauff		Little					
1S. WAS DECEASED EVER IN U. S. ARA (Yes, no, or unknown) (If yes, give war or		16. SOCIAL SECURITY NO 213-03-5936		Springfield	Hosp	ital Reco					
PART I. DEATH (Enter and IMMEDIATE C	ED BY: AUSE (o) DUE TO		4	of the kidney				INTERVAL ONSET AN Mont	ND DEATH		
gave rise to immediate couse (a), stating the <u>under-lying couse last.</u>	(b) DUE TO (c)	AIS CONTRIBUTING TO DE	ATM DIT	NOT DELATED TO THE TERMIN	NAI DISEAS	E CONDITION GIV	FN IN PAR	T 1(a) 19 WA	S ALITOPSY		
C.B.S. assoc. wit Decubitus ul 200. ACCIDENT WAS UNDERLYIN OR CONTRIBUTING CAUSE OF	cers.			without quali			EN IN CAR	PER YES [FORMED?		
OR CONTRIBUTING CAUSE OF OF CHIEF CONTRIBUTING CAUSE OF CHIEF CHIEF CAUSE OF CAUSE OF CHIEF CAUSE OF CAUSE OF CHIEF CAUSE OF CAUS											

ot work p. m. 19 59 to Sept. 21. I certify that (I) (this hospital) attended the deceased from Oct. saw the deceased alive on September 5, 60 and that death occurred ability and on the date stated above.

22a. SIGNATURE 22c. PHYSICIAN'S

foctory, street, office bldg., etc.)

20e. PLACE OF INJURY (Home, farm, 20f. (City or town)

Springfield Hospital, Sykesville, Md.

23a. BURIAL, CREMATION, 23b. DATE THEREOF 9-8-60

23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 23d. LOCATION (City, town, or county) Baltimore

(State)

(Stote)

10151

24. FUNERAL DIRECTOR'S SIGNATURE

20c. TIME OF INJURY

Hour o. m.

ADDRESS

20d. INJURY OCCURRED

Not while

25a. REC'D BY REGISTRAR

MED.

25b. REGISTRAR'S SIGNATURE Cilling S. Frank

(County)

Agustin delCampo, M.D.

Wm. Cook, Inc., 1217 St. Paul Street

START RULE STEEL All for the first to the first the first to enough of the second start solve to the Control of and the season of the season o